

Unearthing the Buried City

The Janet Translation Project

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This document is part of *Unearthing the Buried City: The Janet Translation Project*, a series of AI-assisted English translations of Pierre Janet's works.

In his seminal 1970 book: *The Discovery of the Unconscious: The History and Evolution of Dynamic Psychiatry*, Henri Ellenberger wrote:

Thus, Janet's work can be compared to a vast city buried beneath ashes, like Pompeii. The fate of any buried city is uncertain. It may remain buried forever. It may remain concealed while being plundered by marauders. But it may also perhaps be unearthed some day and brought back to life (p. 409).

This project takes Ellenberger's metaphor seriously — and literally. The goal of this work is to unearth the buried city of Janet's writings and make them accessible to the English-speaking world, where much of his legacy remains obscured or misunderstood.

Pierre Janet was a pioneer of dynamic psychology, psychopathology, hypnosis, and dissociation. His influence on Freud, Jung, and the broader psychotherapeutic tradition is profound, yet the bulk of his original writings remain untranslated or scattered in partial form. These AI-assisted translations aim to fill that gap — provisionally — by making Janet's works readable and searchable in English for the first time.

This is not an academic translation, nor does it claim to replace one. It is a faithful, literal rendering produced with the aid of AI language tools such as Chat GPT and DeepL and lightly edited for clarity. Its purpose is preservation, accessibility, and revival. By bringing these texts to light, I hope to:

- Preserve Janet's contributions in a readable English form
- Spark renewed interest among scholars, clinicians, and students
- Inspire human translators to produce definitive, academically rigorous editions

A Case of Aboulia and Fixed Ideas¹

Pierre Janet

Most authors who have studied psychology have always recommended the study of mental illnesses: they believed, and rightly so, that disturbances of moral phenomena allowed for a better understanding of certain operations of the mind that are ordinarily indistinct. If this advice has been rarely followed, it is because, for such a study, one must be placed in very particular conditions. I owe all my thanks to the physicians who kindly directed my early studies on insanity, and in particular to my eminent teacher Dr. Jules Falret, who allowed me to study under his guidance and to publish this observation gathered in his service at the Salpêtrière. This case, in fact, seems to me interesting and may justify the usefulness of the clinical method in psychological studies. On one hand, it shows the psychologist curious and instructive modifications of certain mental phenomena; on the other, it shows the physician how psychological analysis makes it possible to interpret peculiar disturbances that characterize a fairly distinct group of patients.

The person whom we have chosen as the principal subject of this study is a young woman, twenty-two years old, whom we will designate—entirely conventionally—by the name Marcelle. She presents, to say it in a word at the outset, a disappearance, an almost total abolition of that faculty which is of some importance and which is called the *will*. She is a person entirely without will, an *aboulic*, as they are called. We shall observe in her how this suppression of will manifests itself, how it is demonstrated, and we will arrive at this chiefly through the study of her movements. But we shall especially emphasize the consequences that such an alteration of the mind may have upon the actions that are suppressed or altered, upon ideas, upon memory, and even upon perception. This will allow us, first, to understand well the role of the will, which is much more extensive than is commonly believed, and then perhaps to form a somewhat more precise idea of that psychological fact which particularly deserves the name of will, for it is this principal fact which, in our patient, will appear especially altered. Finally, this study may perhaps clarify somewhat that very important phenomenon of *aboulia*, which is encountered almost always in those patients who are variously designated as hysterics, or neurasthenics, degenerates, phrenasthenics, psychasthenics. In some among them, this symptom takes on such a predominant importance that it gives them a distinct character and allows us to separate, at least from the clinical point of view, the group of the *aboulics*.

1 – Antecedents

¹ Janet, Pierre. “Étude sur un cas d’aboulie et d’idées fixes,” *Revue Philosophique*, xxxi (1891), I, pp. 258-287, 382-407.

It is always rather difficult to obtain precise information about the family of patients, and we have obtained on this one only a small number of details which nevertheless have their importance. Marcelle's father was afflicted with paralysis during the last two years of his life. He died fairly young, around fifty years old, without having exhibited either speech disturbances or delirium. It is difficult now to determine with precision the nature of this paralysis, which is always described in a very vague manner. The relatives on the mother's side are somewhat better known: the maternal grandmother died in an insane asylum; she was very likely afflicted with persecutory delusion. Of her two daughters, one — the aunt of our patient — had a type of intermittent madness and was committed to the asylum in Vaucluse; the other, Marcelle's mother, was never struck by alienation in the strict sense, but she seems to be weak of constitution. She is excitable and easily takes cold, especially when she is with her daughter.

This family had ten children, of whom six are still living; three sons, all intelligent and hard-working, though they are said to have a strong, self-assertive, and selfish character, which seems truly to run in the family. The three daughters are all peculiar. The oldest already shows, though in a milder degree, the same moral tendencies that have constituted the illness of the youngest. They are lazy and even inert; they always seem to be thinking about something else when spoken to, as one of their acquaintances put it. The second daughter in particular, who is the second-to-last child in the family, has periods of distraction and sadness that come strangely close to mental alienation: she sometimes goes fifteen days without wanting to speak to anyone. Marcelle, finally, the youngest child, seems to concentrate in herself—and to heighten—all these various family defects.

Marcelle had a regular childhood, without any accidents. She was lively and fairly intelligent; the only complaint was about her bad temper and her stubbornness. The slightest contradiction, the slightest resistance to her whims would provoke endless sulking and rather violent fits of anger, which ended in tears.

At the age of fourteen, she was struck by an extremely severe typhoid fever, which, as often happens with predisposed individuals, especially provoked cerebral complications. She was delirious for more than a month, recognizing no one and energetically refusing any kind of medication. This illness left deep marks, and it is from this moment that we believe the present illness ought to be dated.

From the time of convalescence, in fact, Marcelle showed changes in character and behavior quite noticeable even to outsiders. She was no longer lively as before, but lazy, moved little, hesitated to get up from her chair, and appeared annoyed by any disruption. Whereas she used to learn easily before her illness, she could now no longer engage in any intellectual effort and learned nothing. Moreover, on the advice of the doctors, she was soon forbidden from doing any such work. She was also very sad, took pleasure in nothing, and rejected all her former amusements. Finally, she became very withdrawn; instead of chatting as she used to with all sorts of people, she completely avoided

strangers, only wanted to speak to the most intimate acquaintances, and even then quite often would retreat to her room without wanting to speak to anyone.

This state of inertia and melancholy was further aggravated, first by the grief caused by the death of her father, which occurred one year after that typhoid fever, then by a romantic attachment that provoked endless reveries and which was, I believe, the beginning of her suicidal thoughts. So that after a few years, Marcelle, then nineteen years old, had become completely unrecognizable and began to present more alarming symptoms. She would remain motionless for very long periods and seemed to find it very difficult to stir herself, even for the simplest acts. People were astonished, for example, that she would call her brothers or her mother to hand her an object that was right beside her, or to open a door next to which she was standing. When she was not obeyed immediately, she would become angry and insulted especially her mother, whom she treated quite harshly. At other times, she appeared seized by inexplicable agitation: she tore her clothes, struck the furniture, and screamed. One day, she was found beside a stack of plates, breaking them one after another in regular succession. Finally, after some time, Marcelle absolutely refused to eat and made several suicide attempts, which necessitated her commitment to the Salpêtrière. Admitted in 1889 to the service of Dr. Falret, she was at first frightened by the sight of the other patients and by the discipline of the institution, and she remained fairly quiet, hiding from everyone the thoughts that agitated her. After a time, she seemed somewhat improved, and they tried returning her to her family, but she could not remain at home and had to return to the hospice this year.

2 – Study of Movements

Marcelle, when one examines her now, is a tall and robust girl who seems well-formed and generally healthy. She walks without difficulty and does not exhibit any signs of physical fatigue. The limbs are well developed and exhibit no deformity or paralysis. The tendon reflexes are normal, and there is no motor or sensory deficiency. The only physical anomaly we observe is a somewhat accentuated formation of the palatal arch.

The most apparent fact that one notices above all in this person, and the first symptom she complains of, if asked, is a peculiar difficulty with movement. She generally remains motionless on her chair, mechanically doing a bit of crochet work, and almost always refuses to interrupt it or to make any kind of movement. When one asks her to make a movement with her arms—for example, to extend her hand to pick up an object on the table that is shown to her—she refuses with a sullen, sulky air. If one insists heavily and for a long time, she slowly lifts herself and slightly extends her hand, then stops motionless and says, “But I can’t,” and withdraws her arm. Then she extends it again a little, stays suspended, makes useless, incoherent movements, and finally, with a sudden gesture, grabs the object; often she puts it back on the table several times before being able to decide to keep it in her hand. These hesitations to pick up a pen or a glass can last a quarter of an hour or even half an hour. More often, however, Marcelle does not persist that long and, after a few unsuccessful attempts, she withdraws her hand

and does not move again; then, in a tone of bad humor, she declares that she cannot and does not even want to try again. It is in this latter manner that things proceed when she is alone. She would not be able to undress herself for bed if she were not helped; she hesitates to touch her dress, manages with great difficulty to lift it slightly, but instead of continuing, she puts it back on and starts over indefinitely. I once found her sitting with empty hands, without her usual crochet work, which was on a table one meter away. "I'm so bored," she said to me, "because I couldn't get my crochet! Please give it to me." Another day, I found her shut up in the room and reproached her for not going out to enjoy a beautiful sunny day: "I tried," she said, "but I couldn't go out, so I stayed in my chair." This hesitation, as we can see from this last example, also affects the movements of the legs. Finally, at certain moments, she remains without answering and cannot even open her mouth; the next day, she recounts that she wanted to speak but could not manage it. In short, all voluntary movements of the arms, legs, even those of the tongue and lips, present the same hesitation and the same powerlessness.

When one sees a person of this kind speak intelligently, complain herself of her inability to move, of this resistance of her limbs to her will—at least to her apparent will—one might, for a moment, consider the possibility of a physical illness of the nerves or muscles causing these disturbances of voluntary movement. But it is enough to observe how Marcelle's movements are modified by the slightest moral influences—how attention, distraction, and different types of memories suppress or increase her hesitation—to dismiss the hypothesis of such an illness and to seek, instead, within cerebral and mental pathology the reason for this powerlessness.

The mental illness one must then consider has been well described in recent years in the works of Morel, Westphal, Legrand du Saulle, J. Falret, Magnan, etc. It is the *delusion of contact*, which Legrand du Saulle considers a particular phase of the *folie du doute* (madness of doubt), while other authors describe it as an isolated symptom. Patients hesitate for a long time before making a movement, because this movement must result in the touching of an object that has become repugnant. Due to some fixed idea or delusional conception, they imagine—against their will—that this object is electrified, poisoned, in short, that it is repulsive and dangerous. Recognizing themselves the absurdity of this belief, they attempt to resist their fear and make an effort to extend their hand, which they soon withdraw in terror. From this arise uncoordinated movements, efforts, and hesitations quite similar to what we observe in Marcelle.

We carefully questioned this person in order to get her to admit to having an idea of this kind, and she did at times give an answer that seemed favorable to this supposition. "It's," she said, speaking of her hesitations, "as if it disgusted me... that object must be dirty." We believe, however, that it would be wrong to give this response too much importance. We are here faced with one of the most common difficulties in experimental or objective psychology. The subject being studied is not, as in other research, an inert object, but a thinking person who examines her own psychological phenomena and who in doing so interprets her illness—not describing it simply as it is, but in the way she understands it. Many

patients, especially melancholics, have perhaps in their delusions only interpretations of certain psychological phenomena that are so subtle they do not speak of them, and which we find great difficulty in uncovering. Well then, when Marcelle explains her hesitations by saying that it must disgust her, I believe she is mistaken about herself and that she misinterprets her own condition.

Indeed, I have surprised her several times in her most intense moments of hesitation, and when I ask her whether she feels a real sense of disgust, she admits that she does not feel it—even when one presses the question at that very moment, she acknowledges that, in reality, she does not at all know where her hesitation comes from. Furthermore, the delusion of contact is usually limited (at least when it is primary) to a few objects that have particularly struck the patient's imagination: doorknobs, brass objects, pins, a piece of furniture, etc. Now, Marcelle herself complains to me that she is wrongly accused of being afraid of doorknobs. Her hesitation is no greater for doors than for anything else; it is general and applies indiscriminately to all objects.

A small experiment can further settle the question. The authors who have spoken of the delusion of contact do not, it seems to me, sufficiently distinguish in their observations two kinds of contact: active contact and passive contact. In a delusion of this kind, one must, I believe, observe the alteration of both types of contact: the patient must not only be unable to touch the object themselves, but also fear the contact if it is brought near them. Now, Marcelle has never appeared to me to show the slightest fear of passive contact. She cannot manage to touch my hand and hesitates endlessly, but she does not flinch and shows no discomfort if I take her hand myself. She cannot touch a piece of paper herself, but she does not recoil or complain if I place the paper on her hands. Often, as we have just seen, she even asks that objects be handed to her. Contact, then, is not repugnant to her, and there is no real disgust; what is disturbed is active contact—the act of making a movement in order to reach the object. But in this phenomenon, the essential element is the movement itself, not the contact, which plays no part here.

What makes the observation even clearer is that one can observe the same difficulty in movements alone, isolated from all contact. Marcelle hesitates to get up, to walk, to speak, just as she does to pick up an object. The same efforts, the same hesitations are provoked in her simply by asking her to raise her arm in the air. We are therefore clearly in the presence of a psychological disorder affecting the motor faculty, the phenomena that govern movement.

It is true that already she is beginning to interpret her illness by saying that objects disgust her. It is not impossible that, if her hesitation continues, she may end up convincing herself of this and that a true delusion of passive contact may one day superimpose itself upon the current disorder. A distinction is, in fact, necessary in delusions of contact: some are primary and usually limited to a small number of objects. These are then connected to fixed ideas, accompanied or not by anxiety, and must be studied alongside them. Justine, for example, another patient whom I will examine later, cannot touch a piece of fruit. It is because this fruit, by association of ideas, makes her think of cholera, and the thought—or even the name—of this illness, which she fears constantly and involuntarily, causes her terrors, anxieties, and even nervous fits. Other delusions of contact

seem to me to be secondary; they apply to all objects indiscriminately and depend on a primary disturbance of movement—on a kind of paralysis that precedes them and is their true explanation. In short, there is a delusion of contact that is merely a fixed idea, and there is a delusion of contact that is the expression of a general disturbance of activity: we will see later the same important distinction in relation to the delusion of doubt. The disturbance of contact that Marcelle presents falls into this latter category, and leads us to study in her the alteration of motor phenomena.

Is this a kind of psychic paralysis, such as one finds, for example, in hysterical monoplegias? Can we say that this young girl has lost her motor images? Can her state be explained simply by saying that the motor convolutions are exhausted, numbed? That might be the case, if the general paralysis involved all voluntary movements equally. But this is not what we observe. On the contrary, despite her apparent motor incapacity, there are many movements that are quite well preserved. To analyze the disturbance in her actions, we must first proceed by elimination and exclude the movements that are intact. (1) The physiological movements—respiration, circulation, etc.—are never disturbed, at least in any grave or apparent way. (2) Her reflexes are entirely normal in the knee, the eyes, the throat; she coughs, blinks, etc. (3) Movements that have become instinctive through practice are likewise intact: she shifts in her chair, changes position, brushes a fly from her face, scratches herself, blows her nose—without the slightest hesitation. (4) Her habitual movements also persist: she does some needlework and carries on with the crochet work—an interminable strip of lace which, it is worth noting, is always the same.

(5) To these various categories of preserved movements, we must add others that are more peculiar. These are complex movements that not only occur without her awareness, like habitual movements, but which, moreover, occur against her will. From time to time, she breaks objects or tears clothes. One day, her parents gave her a lace kerchief, which she liked very much; she could not stop herself from tearing it—she wept with rage as she watched her beautiful lace be destroyed, yet she could not stop until the last pieces were shredded. When she holds a pencil over paper, she begins to draw lines, meaningless scribbles; she finds it ridiculous, but cannot stop until the whole paper is covered with these marks. She also has the habit of biting her nails and has gotten to the point of making her fingers bleed and deforming them entirely; she finds it absurd, ugly, painful, and promises me she will stop doing it—but she immediately resumes. If I scold her harshly, she begins to cry and continues biting her nails while murmuring: “I can’t help it.” Other impulsive movements are, unfortunately, much more serious. She has never been violent toward others, but she tries to kill herself—runs toward a staircase to throw herself down, or tries to jump into a boiler (we will return to these episodes). For now, it is enough to observe that in all such acts, there is no hesitation. She, who can stand frozen in front of a door for half an hour unable to open it, opens it quickly, almost with fury, when it is a matter of one of her impulsive acts.

(6) Experimentation will show us one last category of acts—not only preserved, but even exaggerated. If I ask Marcelle gently and politely to perform an act, she replies, “I don’t mind,” and tries—but the act does not occur. If, on the other hand, I stand in front of her and order her bluntly to perform the act, she is startled and refuses, saying that she does not want to obey in such a way, but nevertheless, the act is carried out completely and without hesitation. In a word, she is extremely suggestible. This suggestibility for actions manifests in all kinds of ways. One can suggest an act to her directly, and she will perform it consciously. One can suggest it to her quietly while she is speaking to another person, and the act will be carried out unconsciously. While she is chatting and not paying attention to me, I lift her arm—it remains in the air without her noticing, even though she is not anesthetic (this is one of those anesthetics and distractions by suggestion that I have often emphasized). When she turns and sees her arm in the air, she lowers it, saying: “I hadn’t noticed.” In the same way, I tell her to stop her work, to resume it, to stand up, to walk, to pick up a paper knife from the table. She performs all these actions without knowing it—but let us note, especially without hesitation. Using this method, one can even get her to pick up a pencil and paper, to write from dictation, or even to answer simple questions: this is the now well-known phenomenon of subconscious writing. It was never very well developed in Marcelle, and such messages never exceeded two lines. But this fact was nonetheless useful in helping me understand the ideas she held deep in her mind. In any case, it is remarkable here, because for two years, due to her hesitations and tremors, she has been incapable of writing consciously—and yet she writes this way quite well. One can foresee that hypnotizing this person is very easy: every method works easily. It is needless to add that she is suggestible under hypnosis—we have just seen how suggestible she already is while awake. But posthypnotic suggestion—that command given during sleep to be executed while awake—offers a useful tool for opposing hesitation in actions that remain preserved. While she is in a state of somnambulism, I make her carry out an action. When I place a hat on the table and tell her to take it and hang it on a hook, then awaken her fully a few minutes later and ask her as if casually: “Marcelle, you should really remove that hat that’s in my way while I’m writing and hang it up,” she replies, “I’m not doing that.” And then she tries to get up, stretches her arms, makes uncoordinated movements, sits back down, and starts over again. I let her struggle for twenty minutes, without her being able to carry out this very simple act. Then I strike the table with a sharp rap. Immediately she stands up abruptly, takes the hat, hangs it up, and sits back down. The act is performed instantly through suggestion—it could not be carried out by willpower in twenty minutes.

All these preserved acts, in fact, from the first to the last, are, with increasing degrees of complexity, what one calls *automatic acts*—and the acts that are lost, as we can now easily see, are the *voluntary acts*. The will, in effect, seems suppressed, or at least extremely diminished in all its manifestations. We are speaking here only of actions and movements. The will has disappeared as the faculty of deciding upon an act in advance, of resolving to make a movement. Marcelle, for a very long time, never makes any decision, not even for the

smallest things. She does not know whether she should go out into the courtyard or remain in her chair, and in the face of this grave question, she remains motionless the entire day, murmuring: "What to do? My God, what to do?" One often encounters people who repeat a phrase of this kind: "What to do?" or "How on earth should I do it?" These expressions are not meaningless; they indicate a particular psychological state, of which we see the ultimate exaggeration in Marcelle. The will is also lost as the faculty of producing a specific movement. The motor power of kinesthetic images—or even visual images—has not disappeared in this patient. When I stand in front of her and swing my arm, it is enough that she sees the movement for her to repeat it. But she no longer knows how to organize or synthesize these images in such a way as to produce a purposeful, useful movement. Finally, the will is lost as the power to stop movements, for automatic acts—whether natural or suggested—are not only preserved, but greatly exaggerated. Any image of such an act becomes impulsive and is not inhibited by the powerless will. The essential symptom of this illness truly deserves the name loss of will, or *aboulia*.

One ordinarily believes one understands easily the meaning of the words: *automatic* and *voluntary*, and the nature of their opposition; but one must nevertheless take advantage of every opportunity to clarify ideas of this kind. Let us analyze further the actions of this person, for her illness presents a remarkable psychological experiment. Instead of considering in her, as we have done until now, the acts that are completely preserved and those that are entirely lost, let us examine the intermediate degrees.

The hesitation and powerlessness of this patient are, in fact, very variable and change depending on the stages of the illness at different times. But even if one studies her on a single day, the hesitation also varies depending on the nature of the actions to be performed, which do not all appear equally difficult. One day, I attempted to train Marcelle in voluntary movements: to do so, I laid out on a table various small objects and asked her to take them one by one and hand them to me. She readily agreed to this sort of game and applied herself to doing it well. Now, despite her good will, she succeeded fairly well in picking up certain objects and very poorly in picking up others. There was on the table a crochet hook that belonged to her, which I had taken from her work, and a small mechanical pencil that belonged to me and which I had taken from my pocket. She almost always picked up her crochet hook quite well, with only one or two minutes of hesitation, but it took her ten minutes or a quarter of an hour to pick up my pencil. I developed several theories to explain this difference, which I initially wanted to associate with the selectivity observed in somnambulists. The true explanation of the phenomenon was given to me only gradually by repeating the experiment.

Indeed, this game was repeated several times, and I noticed that little by little she picked up my mechanical pencil quite well, almost as well as her crochet hook. But it was enough to replace the pencil with another object—a letter opener or simply another pencil—to provoke once again all the intense hesitations of *aboulia*. In other words, she picked up a known object well and a novel object poorly. Once this observation was made, it became easy to verify it throughout all

of Marcelle's behavior. She is totally incapable of speaking to a stranger; it took her two months to become accustomed to speaking to me; since then, she speaks to me easily. One day I took her to another observation room where she had not yet been with me. She experienced, on the threshold, an interminable crisis of *aboulia*, even though she always entered easily into the usual room with me. This characteristic is still visible in the way she walks. Once she sets out in a direction, she proceeds quickly; but if an obstacle appears—or worse, if someone calls to her and she must change direction—she will remain motionless, unable to decide to move. It is always the beginning of the act that is difficult. But it is necessary to clearly understand what I mean here by the beginning of an act; it is not the physical act of setting the muscles in motion once they are ready. That part occurs just as easily when it is a matter of my pencil or a letter opener. What I mean is the formation of that complex ensemble of ideas and images by which one must represent to oneself the act in order to pick up a specific object. This synthesis is not exactly the same for one object as for another, and it is the formation of this synthesis that is difficult for Marcelle, whereas the repetition of the same synthesis, once it has already been made, is easy. To return to the earlier terms: automatic acts are those for which it suffices to repeat a former grouping of images already linked together—in a word, acts once previously willed; and will, as we understand here through its absence, is the formation of these new syntheses. An act is only voluntary by virtue of its novelty.

This conclusion, even while avoiding general discussions and remaining within the observation of our subject, raises several difficulties.

If one asks Marcelle to go and fetch an object she has never picked up before, she does not remain entirely motionless—she gets up, extends her arm, and so on—in a word, she manages to perform part of the useful movements. That is because this act is not absolutely and entirely new; it is composed of a collection of older actions that she can perform easily.

Why then, one might still ask, on certain days of severe illness—as Marcelle too often experiences—does she come to a complete halt and lose even the most habitual acts? She no longer knows how to speak to me, although she has spoken to me a hundred times; she no longer knows how to dress herself, to get up from her chair, etc. I will respond with an assertion that may seem paradoxical—one to which psychologists have not paid sufficient attention, but which the clinical study of mental illness here makes quite evident. It is that there is no act so absolutely familiar that it does not contain a small part of novelty. Getting up from one's chair today is not quite the same thing as having gotten up yesterday: the weather, the temperature, external circumstances, the state of the body and mind are no longer exactly the same. Speaking, even to a very familiar person, is always a new action in some respect. The person one speaks to, their clothing, their expression, the topic of conversation—all of this changes. “One never bathes twice in the same river,” said the old sage: the universe changes incessantly, and no matter how much the circumstances in which we are placed seem the same, there is always some change—either outside or within us—that requires a new adaptation, a new effort. Since the future is never an exact repetition of the past, a conscious act is never a completely automatic act. One must always make an

effort, invent, will—at least a little—even to repeat the most habitual action. And when Marcelle's will descends to a truly low level, I am not surprised to see her lose even her most habitual acts.

The third difficulty I encounter in explaining Marcelle's actions troubles me much more. Why is it, then, that at the very moment when she is incapable of performing a new act by will, she performs it so easily under suggestion? The act of picking up a letter opener she does not know is, after all, just as difficult, just as new, whether she does it following a suggestion or by her own free choice. I admit, I am quite puzzled in trying to account for this strange phenomenon. The explanation that seems most plausible to me is this: these two acts, despite appearances, must not be psychologically identical. The consciousness of the state of the personality at that moment, the notion of the object, the awareness of the varying external circumstances—all the elements that constitute, as we have said, the act of voluntary synthesis—exist only in the act carried out voluntarily. The act done under suggestion takes place in a narrower, more limited consciousness, and does not require the synthesis of all these details, because it assumes none of them are conscious. Marcelle has just picked up the letter opener under suggestion and brings it to me with rapid movements. "It wasn't me," she says with a troubled look, and she always repeats this phrase whenever she performs such an act; she has not linked this act to her personality. She acknowledges that she had no personal awareness of the images necessary to accomplish it. Often, moreover, the act is completely subconscious, and Marcelle is entirely unaware of it. One must not conclude from this that the act is carried out by a second, inferior personality, as in some hysterical patients I have described. I have not observed in Marcelle the clear formation of a simultaneous second personality: the automatic writing, which remains rudimentary, does not present those continuous chains of subconscious memories that constitute a doubling of personality. No, the images associated with this act have not been tied to any personality; they have occurred in isolation, in connection with the words of the command. In this suggested act, there is likewise no notion of the object or of the goal of the act. When Marcelle voluntarily tries to pick up the letter opener, she knows it is a letter opener that she is to take, that it is to hand to me, and for the purpose of practicing movements. She has picked up the same object by suggestion, and if I suddenly ask her what she is holding in her hand, she does not know. I ask her why she is picking up this object, and she does not know what to answer. Subconscious writing, moreover, does not answer these questions any better. In a word, if I may say so, the act performed under suggestion is an *abstract* act, stripped of all notion of personality, of object, of goal—elements which are part of the voluntary act and which make it perpetually new.

We therefore believe, despite these difficulties, that we can maintain our previous conclusions. Marcelle is an *aboulic*; she has a considerable diminution of will, along with preservation and exaggeration of automatism. That is to say, she no longer knows how to perform new acts in response to new circumstances, but contents herself with repeating former acts in an abstract manner, without adaptation to new situations or new needs. Such are the initial conclusions we can

draw from the study of her movements—rapid and impulsive when they are automatic, hesitant and often impossible when they are voluntary.

3 – The Fixed Ideas

After having analyzed this person's movements, let us try to penetrate further into her thoughts and to know what ideas she may have. For that, it is necessary no longer to observe, so to speak, from the outside, but to gain the patient's trust and to converse with her frequently. One immediately notices very different states of mind that are important to take into account. She is not always found in the same condition; sometimes she speaks well, expresses herself rather cheerfully; sometimes she is gloomy and refuses to say a word. When I come near her during one of these bad moments, she does not seem to notice my presence; she stares fixedly downward without moving her eyes; if I shake her sharply, she does not react or lets out a growl of anger. The next day, I find her in good spirits and quite willing to talk with me: "First tell me what you had against me yesterday to receive me so badly."

"Yesterday? But you didn't come!"

"Excuse me, I stayed half an hour by your side."

"I didn't see you."

"What were you thinking about, then?"

"I don't know."

These words already indicate that we are dealing with an important state that leaves no memory behind. It is necessary to understand this state first, for knowing it will allow us to better understand the patient's usual thoughts during the intervals that separate two episodes.

One day, by chance, we were able to see one of these strange attacks begin and end before us. Marcelle was speaking with some liveliness; her facial expression showed adequate mobility; she moved her eyes from side to side, although—as is her bad habit—she would not look people directly in the face. Suddenly, without any clearly appreciable preliminary signs, she stopped speaking and remained absolutely motionless, her face rigid. She seemed more frozen than usual; when I lifted her arm, it stayed suspended in the air in whatever position I placed it, like in a kind of cataleptic stupor. This sort of attack lasted for more than a quarter of an hour and might have continued even longer if she hadn't seemed to make an effort upon herself, as though partially waking, and turned toward me as if she had just noticed I was there. When I questioned her, she replied: "It's nothing; it's just my thoughts that passed by like a cloud." I found this expression vivid, and in describing this patient I've adopted the word *cloud* to designate this type of episode, and I committed myself to discovering and understanding what took place in her mind while the cloud passed.

This study of the cloud presented great difficulties. During the crisis, she does not respond, and after the crisis she seems to have forgotten everything. Nevertheless, little by little, I was able to gather some information through various methods. (1) In certain light and transient attacks, I managed to obtain from her a few words and a few signs; (2) At the end of the episode, in that

transitional period often marked by weeping, she has enough memory to give a few indications, which she forgets the next moment; (3) By putting her into a sufficiently deep sleep, it is possible to reproduce episodes analogous to the cloud in several respects, but in which she remains in contact with me and can respond to me; (4) Finally, automatic writing, which—as we have said—exists in this subject, has provided us with various bits of information that no other method could have obtained.

By grouping these various pieces of information, we will say that the cloud is a kind of crisis of ideas, so to speak. It is a period of very variable duration, which may not exceed a quarter of an hour, or may last for days or even weeks. During this period, the patient seems plunged into a state of sleep traversed by dreams; she is no longer at all in relation with the external world, knows nothing of what is going on around her, and gives herself over entirely to the automatism of certain ideas, which are more or less always the same, and which unfold regularly in her mind. Suppose a hysterical crisis from which the convulsive movements have been removed, retaining only the delusional ideas, and one will have an idea of Marcelle's crisis. Certain small signs, moreover, justify this comparison. If one observes closely, there are some slight convulsive movements of the eyelids and eyes, a slight constriction of the throat at the beginning of the attack; there are sighs and tears at the end. In a word, the convulsive phenomena of the hysterical crisis are attenuated to the point of almost completely disappearing, and only the mental phenomena of the delirium remain. But the convulsions can reappear, as we shall see later, and justify our comparison of the cloud with the rudimentary forms of the hysterical crisis.

The ideas that invade the mind at that moment always have the same character. They appear in the form of extremely vivid or complex images that are contradicted by nothing and that give the patient the complete illusion of reality. Let us note this well, for it is an important point for the theory of this illness: Marcelle never has any doubt, any hesitation about the ideas—even the most absurd ones—when she is plunged into the cloud. These ideas are not then thoughts more or less weighed, about which the subject questions herself; they are always accompanied by true hallucinations.

I believe it is necessary to insist upon these hallucinations, the existence of which has been contested in obsessive patients and which, on the contrary, seem to me to be frequent and important.

Let us review some of these hallucinations, beginning with the least frequent. Marcelle has never had, I believe, hallucinations of taste, smell, or touch. She sometimes has auditory hallucinations and tells me she hears noises, music. Sometimes she starts, turns her head to the side, and seems to be listening; that is when she hears herself being called from afar—but this is rare and happens only during the very major attacks.

Much more often she has visual hallucinations: she sees black creatures moving in front of her; she believes her bed is covered with mice that want to gnaw her wrist. She sees, off to the side, people who are pursuing her, who want to kill her; they have horrible faces, and she is very frightened, yet cannot move. For several months she has had a crisis of visual hallucinations that is much more

significant and more characteristic. About six months ago, during a short outing she made outside the hospital, she was subjected to a distressing scene that made a deep impression on her. We will later speak of this scene in detail. Since that event, Marcelle has a nightly crisis in which the scene is reproduced: the same setting, the same characters, the same attitudes are exactly repeated, and this poor patient remains for entire days absorbed in this contemplation. All these hallucinations—except perhaps the last one, which is serious—form only a minor part of the phenomena filling her mind during the cloud. They ordinarily give way to a category of images much more frequent and more important.

Since this new phenomenon occupies an important place in the illness we are studying, and since, on the other hand, it is still little known and rather difficult to understand clearly, we must insist on it a little. Marcelle, in a word, complains that during the cloud “someone speaks” in her head, that her “head speaks constantly.” What does she mean, and what is it about?

For a long time, authors who have described the insane have observed that a certain number of these patients complain that someone is speaking to them, but this phenomenon is not of the same kind in all cases. Some of them—the simplest—are easily understood. Here is, for example, a persecuted woman who complains of being tormented by her sister Joséphine: “It is unbearable,” she says, “that Joséphine can get in everywhere! When I was at Ville-Evrard, she positioned herself in the room above my bed, from where she constantly insulted me. Now I come to the Salpêtrière, and Joséphine is still there, in the room above the infirmary when I sleep, and in the room above the workroom when I work.”

“Are you quite sure that Joséphine could have come in here?”

“Certainly, I can clearly hear her voice, I recognize it: let me go up to the room above, and I will show you that Joséphine is there.”

This description is immediately understandable: the patient hears actual voices with a recognizable tone, a specific external localization, etc.; these are hallucinations of the sense of hearing. But here are other, more puzzling patients. “Someone is speaking to me all the time,” says one of them. “I am told that I must go and ask the Pope for forgiveness.”

“Do you recognize the voice that is speaking to you?”

“No, I don’t recognize it, it is no one’s voice.”

“Is this voice far away or nearby?”

“It is neither far nor near; it feels like it’s in my chest.”

“Is it like a voice?”

“No, it’s not a voice; *I don’t hear anything*, I feel that someone is speaking to me.”

This phenomenon has perplexed all alienists. Some have called it a psychic hallucination, which explains little; others have given it the name epigastric voice, which approximately indicates its usual seat, but not its nature. It is the recent theories on language and the images that constitute it which have allowed this

mystery to be clarified. Several authors have vaguely suggested this explanation, which M. Séglas has formulated in a definitive way.²

Language is a very complex psychological fact. It is represented in our mind by numerous and different images drawn from different senses. It comprises, in fact, auditory images—the sound of the word ‘bell’, for example; visual images—the sight of the word ‘bell’ written or printed; and finally, tactile and muscular images, residues of all the sensations we experience in the throat, the tongue, the lips when we pronounce the word ‘bell’, and sensations experienced in the arms, the hand, the fingers, when we write this word. One knows that M. Charcot drew from this observation his theory of the various types of language—auditory, visual, or motor—and that he gave the latter name to the language composed of the tactile or muscular images we have just mentioned. Applying these doctrines to insanity, M. Séglas concluded that there can exist as many kinds of verbal hallucinations as there are kinds of language. Some would be auditory hallucinations of language, others visual hallucinations of writing, and finally, a third category would be formed by hallucinations of those tactile and muscular sensations that constitute Charcot’s motor type. And these hallucinations, which M. Séglas calls *psychomotor verbal hallucinations*, would be precisely the psychic hallucinations or the epigastric voices of the insane.

The observation of patients comes to confirm this supposition: one often observes real movements of the mouth or of the tongue, and even the actual pronunciation of those words that the subject claims to perceive mysteriously. I myself have reported, several years ago, a very conclusive example.³ The patient realizes herself that she is moving her tongue. “I don’t hear it,” she says, “but I’m going to pronounce it—I place my hand under my mouth to feel it.”⁴ — “When I used to speak from the heart,” she says, speaking of the origin of her hallucinations, “now I feel very well that I’m moving my mouth. It’s as if my sister, her husband, were in my stomach; it’s as if they were making my tongue move from the bottom of my chest... my tongue itches all the time because of it.”

I will add another piece of evidence: this patient cannot manage, when I ask her, to speak at the same time that she feels her voices. “It’s as if,” she says, “something is in my cheeks that prevents me from speaking at that moment.” The patient cannot manage to have, at the same time, two images from the muscular sense of the tongue. This observation recalls one of M. Stricker’s experiments to demonstrate the muscular nature of verbal images in certain individuals.

We see, from these examples, that we fully adopt M. Séglas’s theory of epigastric voices. But, since it is very difficult to be completely in agreement on such delicate questions, we will offer this author a small criticism of wording. He designates this phenomenon under the name of *psychomotor verbal hallucinations*: this expression has undoubtedly been useful for making a delicate

² J. Séglas, De l’hallucination dans ses rapports avec la fonction du langage, les hallucinations psycho-motrices. *Progrès médical*, August 18 1888, p. 124 and 137, and *Les troubles du langage chez les aliénés*, Paris, Rueff., 1892, p. 117.

³ *L’automatisme psychologique*, Paris, F. Alcan. 1889, p. 432.

⁴ These observations and the following ones are taken from patients in the service of Mr. Falret or from the outpatient clinic.

psychological phenomenon understood; its analogy with the term motor language used by M. Charcot contributed to its clarity. But from a purely scientific point of view, and in order to indicate clearly the place of these hallucinations among psychological phenomena, is this expression perfectly accurate?

Why reserve for this particular phenomenon the name “psychomotor”? Do not all mental phenomena today have that well-known character of being psychomotor? Is not an image, an auditory, visual, or tactile hallucination accompanied by phenomena of movement—adaptation of the organs, expression in the face, associated movements, etc.? Certain individuals, like hysterical anæsthetics, make use only of visual images to carry out their movements, and for these persons, a visual hallucination could perfectly well be called a psychomotor hallucination. This word therefore has a very vague meaning, whereas the author wishes to speak here not of indeterminate hallucinations, but of a much more precise phenomenon.

When one describes a hallucination, it is necessary above all, we believe, to indicate which sense is involved, to which category of sensations it belongs. In the present case, it is important to make known that it is not a psychomotor or vague image, but an image of that very important sense that one calls the muscular sense—or better, the kinesthetic sense. We therefore divide hallucinations, as we do sensations, into auditory, visual, etc., and kinesthetic hallucinations. Let us further note that in each of these categories, hallucinations can vary according to the objects they represent: the patient may see a man or a written word and have a visual hallucination of a man or a graphic visual hallucination. The same holds for hallucinations of the kinesthetic sense; there may be some that do not relate to language. The patient we are studying, Marcelle, has in fact presented us with a curious example. One day she attended an electrical session in Charcot’s ward and saw patients suffering from chorea. She told me afterward that she did not want to go to that service anymore, because it made her worse and gave her Saint Vitus’s dance. “I clearly feel,” she said, “my right arm moving all the time; it only stops when I look at it.” Now this was entirely false—her right arm was not moving—but she imagined that it was. We can relate this fact to another patient, whom I will study in more detail elsewhere, who had a hallucination of trembling. These are hallucinations of the muscular or kinesthetic sense, and yet they are not verbal. To fully characterize the former epigastric voices, one must therefore add the word verbal and say that this phenomenon consists of verbal kinesthetic hallucinations. The word ‘kinesthetic’ changes nothing, no doubt, in M. Séglas’s theory; it may be less convenient, but it seems to us more precise.

Once the general nature of these hallucinations is recognized, one must ask what their content is. What are these voices saying? It is certain that we must here ignore the theories invented to explain ordinary hallucinations. In the case of F., for example, the patient merely echoes, in a whisper, all the words she hears spoken around her; this is a low-grade degree of echolalia.⁵ Another, B., repeats involuntarily the names of the objects she sees while walking: “That’s a tree,

⁵ M. Séglas has already reported two similar cases (Deux cas d’onomatomanie, écholalie mentale. *Société médicale des hôpitaux*, April 12 1889).

that's a pile of garbage," say the voices when she is in the street. It is a kind of visual echolalia. In other cases, the phenomenon becomes more complicated: the interior voices of F. proceed by puns, those of B. by associations of ideas. I was speaking one day with a man suffering from this illness. I was advising him to avoid alcohol and to follow a sober and tonic regimen. He appeared to be listening to me absentmindedly. "They're speaking to me again inside," he said.

"What are they saying to you?"

"Nonsense."

"What nonsense?"

"They keep repeating to me: watercress... watercress..."

Finally, the voices can become even more complex: they repeat a sentence the patient once heard and that deeply moved him, or they reproduce ideas that once struck the imagination. A poor, somewhat simple-minded woman, R., once heard her concierge describe an asylum she had just visited. "Can you imagine," the concierge told the frightened neighbors, "there are poor lunatics who believe they're queens!" R. returned home in great distress, and since then, she almost constantly hears an interior voice repeating to her: "You're a queen, your husband is a king... the courtyard is coming... you must clean the stairs...", etc. We see that these verbal kinesthetic hallucinations can pass through all degrees of complexity, like dreams or the automatic writing of spiritist mediums.

We have insisted on this phenomenon because it is very important to understand for our study: it is what fills the greater part of Marcelle's clouded episodes. This patient claims, in fact, that during the cloud someone is saying a great many things to her, that her head is full of ideas. She exaggerates a little; it seemed to us that these inner discourses, though frequent, were little varied and repeated themselves strictly, one like the other, like the delusions of a hysterical crisis.

We note first in these discourses fairly prominent ideas of persecution, common in this type of patient. Marcelle repeats to herself that her mother wishes her harm, that her brothers hate her, that everyone wants to harm her, or else that everyone avoids her as if she were the plague, that everyone is afraid of her, etc. These very monotonous ideas vary only by the person designated. Thus, upon her arrival at the hospital, she was very upset when she saw Dr. Falret, who, however, does not have a very frightening appearance, and in all her clouded states she would repeat: "Dr. Falret—yet another who has it in for me, another who has it in for me." These persecutory ideas develop, but very slowly; after a few months, she would say during her episodes: "My mother is not my mother, my brothers are not my brothers, I am not from their family... they locked me up to dispossess me." Despite this appearance of logic, these persecutory ideas—which, moreover, only appear with such clarity during the crisis and in the form of automatic speech—do not have at all the coherence or systematization found in true paranoiacs. When she speaks of these ideas during somnambulism, she asserts them stubbornly, but cannot justify them at all. She does not invent reasons to explain this universal hatred and says, moments apart, without concern for contradiction, both 'that everyone in the hospital is against her' and 'that

everyone is kind to her.' She doesn't even seem to understand herself the meaning of these phrases. "You're against me too," she said to me.

"You think I want to harm you?"

"No, I know well that you don't want that."

"Are you afraid of me?"

"Not at all, since I come with you all alone and it doesn't bother me."

"So what does it mean then: 'you're against me'?"

"I don't know."

These ideas are accompanied during the crisis neither by pride, as in paranoiacs, nor by humility, as in melancholics; she notes this universal ill-will as a fact to which she can do nothing—or rather, she does not connect this idea to the whole of her other thoughts; she suffers this idea like something foreign, just as a medium does not apply the ramblings of automatic writing to herself. Alongside these ideas of persecution, we notice other phrases of considerable importance. These are sorts of commands or prohibitions that persist tenaciously in her mind. The most important one is this: "You must die, everyone must die, the sooner the better...", or else: "Don't eat, don't walk, don't speak, you have no voice, you are paralyzed..." These are harmful suggestions, as we shall see, which she only remembers during the clouded episodes, but which have a very great influence on her life.

We believe we can include these ideas of Marcelle in the group of fixed ideas, although they do not absolutely resemble the conscious fixed ideas as they are ordinarily described in obsessive patients. These ideas of Marcelle, in fact, have important characteristics that bring them closer to them: they are irresistible, develop without the patient's consent, and reproduce themselves regularly in the same way without being modified by external circumstances—these are the principal features of automatic psychological phenomena. Moreover, they have, as we will see, the closest relation to the conscious obsessions of the patient outside the clouded episodes.

Before abandoning the study of these sorts of fixed ideas appearing in the form of crises, we must make one remark about their origin. Nearly all of these ideas—and probably all of them, if we knew the patient better—have their origin in some memory of past life. These ideas do not seem to me to be conceived or invented at the moment they are now formulated; they are only repetitions. Thus the most important of the visual hallucinations, the one that tormented Marcelle all winter, was merely the exact reproduction of a scene that had occurred the previous year. The fixed ideas of dying, of not eating, are the reproduction of certain desperate resolutions taken several years ago. Formerly, these ideas had a meaning and were more or less connected to some motive. A heartbreak had been the cause of her suicide attempts; she refused to eat in order to let herself die of hunger, etc. Today, these ideas reproduce themselves without any connection among them and without reason. She has completely forgotten—this I am convinced of—her former despair and has no desire to die. The idea of suicide now appears without any relation to the present situation, and Marcelle despairs at the thought of this suicide which imposes itself upon her like a remnant of the past. She no longer knows why she refuses to eat; the ideas of suicide and of

refusing food have become dissociated—one exists without the other. At times, she hears the voice saying to her: “Do not eat,” and does not think of dying; at other times, she thinks of killing herself and yet accepts food. Always we find in fixed ideas this characteristic of automatic repetition of the past, without connection, without relation to present external circumstances—in other words, without any present synthesis.

The ideas of persecution would perhaps be more difficult to explain. These ideas are, in fact, so frequent in all individuals whose mind is weakened that one might wonder whether they do not have some general cause. Should we relate them to that egoism, so characteristic of weak intelligences—to that hypertrophy of the self, of which certain authors speak without clearly explaining it? Should we, as I might be inclined to believe, relate them to a particular alteration of the intelligence, a disturbance in the knowledge of men—in that perception of humanity at least as important as the perception of the external world? These would be important investigations both for experimental morality and for psychology. But they should only be undertaken by studying in detail true paranoiacs, and not someone in whom these ideas are certainly episodic. They must be connected to some family scene that we do not know well. One of these ideas, which developed before our eyes, shows us how much the accident of circumstances plays a great role here. A young girl had just been placed in the same ward as Marcelle and, since she was not very ill, contrary to the usual behavior of insane patients, she tried to make acquaintances with her neighbors. This person approached Marcelle and tried to speak to her, but met with our patient’s bad temper and said aloud: “Oh! Mademoiselle, what evil looks you give me—you frighten me!” That was enough to modify Marcelle’s crises. For several days, her voices kept repeating to her: “Everyone is afraid of you, everyone avoids you,” etc. The persecutory ideas relating to her parents must have had an origin of the same kind.

Such, then, are the principal phenomena that fill the clouded episode; we have emphasized this state because it seems to us to play a major role in the illness and because it rarely presents itself with as much clarity as in Marcelle. In other patients tormented by fixed ideas of this kind, the crises are more frequent; one observes only confused indications of disturbances of personal perception during them, of disturbances of memory, and the distinction between the period of the crisis and that of the normal state is less clear—there is a confusion of the two states that renders the study more difficult. Despite the word by which they are often wrongly designated, these ideas are far from being entirely *conscious*—that is, entirely known to the subject himself. One must remember the existence of this state in which the fixed ideas develop outside the normal consciousness, as if in a second state, a somnambulism.

The clouded episode is over. Marcelle awakens slowly, sighing and weeping, and little by little she regains her normal appearance and returns to her occupations. In appearance, all those hallucinations, those fixed ideas, those commands that filled her mind during the crisis are erased. Marcelle can no longer, despite her efforts, recover the memory of them in order to recount them

to us. But we know that in the human mind, nothing is ever lost and that there are persistent traces after the crises, after dreams, just as after somnambulistic episodes. In reality, the phenomena that occurred during the cloud have an extremely serious influence, even on the intervals of lucid thought.

We will first note certain attitudes, certain movements that are almost completely subconscious, which persist even after the awakening. When she has dreamed of her persecutory ideas, she remains gloomy, looks at people askance, jumps in fright—although she affirms that she is not afraid of anything and is not angry. One day, she headed toward a staircase, stopped on the first step, then walked away without understanding why she had gone there; it was a subconscious movement, due to the suicidal ideas that previously dominated. Another time, she spent part of the day looking at her wrist and asked if anything could be seen on it. “I thought there was something wrong with it,” she said. During the crisis, she had dreamed of mice eating her wrist. In this connection, one recalls that patient of Charcot who claimed to see bite marks on his body when, in his crisis, he had dreamed that he was fighting off dogs.⁶ These are examples of those movements that persist subconsciously.

A second category of phenomena of the same kind will consist of the ideas, the absurd beliefs that we have noted during the clouded state; they still exist, but they do not present themselves in the same manner. This difference in the nature of the fixed ideas may seem a bit subtle, but we consider it important for understanding the madness of doubt. To make it clear, we will take two examples and report faithfully the way in which Marcelle expresses one of her delusional ideas when she is in her waking state and when she is in the crisis. We believe that in this way one will better grasp the difference we are trying to indicate.

Marcelle is thus in one of her most lucid moments, and I approach her, asking about her health. “I have a terrible headache,” she tells me, “and it’s a very peculiar kind of pain.”

“What’s peculiar about it? Tell me.”

“Oh no, you’d make fun of me.”

“I promise I won’t.”

“It’s like there’s a creature in my head, gnawing at my brain.”

“What are you saying? You know very well that’s not possible.”

“I don’t know... sometimes I believe there’s a creature, sometimes I reason with myself and no longer believe it; I debate it all day long. Tell me, seriously, is it possible that I have a creature in my head?”

“No, I assure you, you have a headache, and that’s all.”

“Ah, good, I prefer that.” She walks away, delighted and reassured; half an hour later, she says to a nurse: “Still, Mr. Janet could be mistaken—I must have a creature in my head.”

In this brief conversation one can observe the four characteristics of obsession in the madness of doubt, such as Legrand du Saulle pointed out:

(1) The subject doubts her delusional idea and argues against it; (2) she feels the need for reassurance, seeks affirmation from another; (3) she is easily convinced

⁶ See the study of facts of this kind in *Psychological Automatism*, p. 248 and following.

and seemingly renounces her delusion; (4) the obsession reappears almost immediately, without any change.

Let us resume our conversation with Marcelle on the same subject, but at another time: she is asleep, in a deep somnambulatory state similar to the clouded crisis, in which she retains the memory of that episode.

“You told me,” I say to her, “a strange story: you know perfectly well you don’t have a beast in your head. That’s a made-up story.”

“You’re teasing me,” she answers, “but it really seems like a beast. No, no, I’m telling you, I have one in my head, it got in, it’s eating my brain—I’m absolutely sure of it.”

If I insist and try to reason with her, she stops responding altogether. This is clearly a hallucinatory conviction, just like those we described earlier. All my efforts to convince her proving useless, I change my approach: “Well then, yes,” I tell her, “I was wrong. But since you have a beast in your head, we’ll have to perform a little surgical operation.”

“Oh yes! Let’s do that, I agree.”

I won’t describe this operation performed by suggestion on a somnambulatory subject; its details are easy to imagine: the beast was removed and crushed on the floor before Marcelle. I did not question her upon waking about this idea—this is something best avoided after such suggestions, so as not to reawaken a fixed idea that has been poorly erased. But I did observe that for five months, Marcelle has never spoken again of a beast in her head. We see here the inverse of all the earlier traits: the subject does not doubt her fixed idea, does not ask anyone to confirm it, cannot be convinced by ordinary methods—but once the cure is obtained, it remains much more stable.

This comparison is interesting because it shows us a way to understand the obsessions in the illness of doubt—this discussion, this ‘psychic rumination’ that accompanies it. These obsessions have, at least in the present case, their origin in a deeper state: they were in that state clear, affirmative—they had the form of fixed ideas and hallucinations. But now the state that gave birth to them has disappeared; they persist only half-erased, yet tenacious, and must therefore enter into conflict with consciousness and ordinary good sense.

We can now understand the peculiar way in which Marcelle speaks of her parents during her lucid intervals. She does not know what to think about them; she discusses and questions herself endlessly: “Is it true,” she says to herself, “that my parents are against me? That’s very strange. Why would they be against me? What did I do to them? Why is that girl afraid of me? Why do people avoid me? Have I committed crimes? Am I dangerous?” Sometimes she arrives at answers, but they do not satisfy her and give rise to new questions: “If my brothers persecute me, it’s because they have something to gain. If my mother is against me, it’s because I’m not her daughter. But I’m still my father’s daughter. How did he bring me home? When did the child-swapping happen?” Let us add that this young girl, at the beginning of her illness, read with passion all the serialized novels, and one can then understand what romantic constructions, what ravings she arrives at in this line of questioning. But however extravagant these discussions may be, I repeat that, in my opinion, they are not pathological. They

are the natural and necessary reaction of any mind against the fixed idea that imposes itself. Only the point of departure was pathological, and it is due to the persistence of that verbal kinesthetic hallucination observed during the crises.

After these internal ramblings, we will note a third consequence of the cloud: it is that she executes, despite herself, during lucid states, the commands that her hallucinations gave her during the cloud. The voice said to her: "You have no speech anymore, you can no longer speak," or "You can no longer eat," and now here she is, unable to speak to us or obstinately refusing to eat. No matter that she acknowledges it is absurd, no matter all the promises she makes me—it's all useless; as soon as she sits down at the table, she clenches her teeth and cannot open her mouth. Then the period of interpretation arrives: "If she cannot eat, it is because she does not need to; she no longer has the same stomach as before; she is not hungry; she has a stomach made of cardboard; she is completely changed," etc. Quite naturally, these interpretations, which are first expressed with doubt and hesitation to explain her resistance, will be transformed, at the next cloud episode, into hallucinations—and thus, once the illness has entered into this vicious cycle, the crises will become stronger and stronger and the lucid intervals increasingly less lucid.

To better understand these two states and the influence they have on one another, a comparison seems appropriate. Marcelle, in the spontaneous side of her clouded state, behaves like a person who has received, during somnambulism, a posthypnotic suggestion. The action then appears later, almost fatally, as a decision made without the subject's knowledge, as one sees more clearly in anesthetic or very distracted individuals. In a more sensitive and less distracted person, the action torments the mind, presents itself as a fixed idea; the subject interprets it, debates it, tries to resist, etc. To justify this comparison, I carried out the following experiment. During somnambulism, I gave Marcelle a posthypnotic suggestion, but I chose an act sufficiently difficult that it would not be executed abruptly and without consciousness. I told her to come remove an apron I was wearing, which, given her shyness, is a complex and serious act for her. Thus, she does not perform it upon waking, but she stops speaking, looks at me askance with a sullen air—in short, she entirely takes on the attitude that characterizes her when tormented by an obsession. If I question her, she responds: "It's one of those ideas again that's tormenting me." She is perfectly convinced of the identity between my suggestion and her fixed ideas and feels no difference. This experiment having seemed interesting to me, I repeated it with another patient, D., who is tormented by impulses similar to Marcelle's obsessions. A suggestion I gave her during somnambulism was taken by her as one of her natural impulses, and she felt no more distinction. (It goes without saying that after this experiment, one must re-hypnotize the subjects to remove this artificial impulse which would otherwise increase their distress.) Thus, we see that these two things—obsessions and posthypnotic suggestions—have strong analogies, and the now known laws of the latter may thus help us understand the former.

This influence of fixed ideas on all of Marcelle's behavior being well understood, one may ask whether it alone would suffice to explain the entirety of

this person's illness and could account for the first symptom noted, the aboulia itself, and all the other psychological and physiological disturbances we have observed. This is a serious question: is it the aboulia that precedes the fixed ideas, or are the fixed ideas the ones that have provoked this trouble, this hesitation of movements? At first glance, one might be tempted by this latter hypothesis. Indeed, we have noted on several occasions, during the clouded state, verbal hallucinations saying to Marcelle: "You are paralyzed, you can no longer move." She herself has told us of strange dreams she has at night; she imagines herself sick and struck with total paralysis. For anyone who now knows this person, it is easy to predict that such dreams will have a most harmful influence on all her movements. One might ask whether they do not suffice to explain all the symptoms of hesitation and powerlessness. Marcelle would then be simply a patient suffering from fixed ideas and, among others, having the fixed idea that she is paralyzed. There would remain the task of explaining the origin of these fixed ideas of paralysis. Now, in a very remarkable treatise on psychology, M. Paulhan has proposed a hypothesis to explain the origin of these fixed ideas of impotence in the madness of doubt. These ideas would be due, according to the author, to an *exaggeration of association by contrast*.⁷ At the moment of carrying out an act, patients would automatically have in their mind the idea opposed to the act they want to perform—or rather the idea that contrasts with their dominant tendency. An honest person (M. Paulhan cites an old observation by Esquirol) would think of theft; a chaste person would have impure thoughts, etc. These opposing ideas would then come into conflict with the thought of the action one wishes to carry out, and from there would be born doubt or aboulia. In a word, if I correctly understand the passage by M. Paulhan concerning the delirium of doubt, the fixed ideas would be primary and due to an exaggeration of association by contrast; doubt or aboulia would be secondary.

We have no intention of discussing Paulhan's entire theory of contrast, which seems to us, moreover, to be true on many points. But we want to show that the author makes an overuse of this theory when he tries to explain by it a psychological illness as complex as the madness of doubt or aboulia.

(1) We must first present a general proposition: M. Paulhan opposes, as two distinct groups from a psychological point of view, the honest people and the patients affected by the delirium of doubt. The former would be characterized by a diminution or suppression of association by contrast, which would explain their impulsive actions. The latter, on the contrary, would present an exaggeration of association by contrast, which would be the reason for their doubt. We do not believe that the observation of patients justifies this opposition; on the contrary, we would be inclined to bring closer together the delirium of doubt and hysteria, perhaps even to make them two forms of the same mental illness. In any case, one thing is certain: that at least some aboulie patients, like Marcelle, are just as suggestible as hysterics, and therefore, according to M. Paulhan's theory, associations by contrast should not be developed in either group.

⁷ M. Paulhan, *L'activité mentale et les éléments de l'esprit*, 1889, 341–357, Paris, F. Alcan. An analogous explanation of the madness of doubt had already been proposed in Italy: A. Raggi, *Fenomeni di contrasto psichico in un'alienata*, *Arch. ital. p. l. mal. nerv.*, 1887.

(2) Can one admit, one might ask again, that the fixed ideas, the obsessions that arise in the minds of these patients, are truly in contrast with the action they wish to perform? To examine this, let us take together a number of such patients, place them all in one and the same situation, and see what fixed idea arises in each of their minds. These people are in their room and, for some reason or another, they wish to open the window: immediately, Ain. has the fixed idea of throwing himself out the window, Du. feels the urge to grab a piece of furniture and throw it down on a passerby to crush him, F. is convinced that she will break the window panes if she gets close, Vi. has the fixed idea of signaling to a man to come up, and finally, Marcelle simply tells herself that she cannot open the window, that there is no point in trying. These are not examples made up for the sake of argument, but real facts observed in patients from the ward or the outpatient clinic. How can these ideas all be the contrast of the action of opening the window? In what way is the act of signaling to a passerby to come up in opposition to the act of opening the window? One might say it is in opposition to Vi.'s dominant tendency, which is modesty. But then I ask: why is Vi.'s modesty awakened at the very moment she opens the window, and why would she alone be considered modest?

If we put our patients in another situation, we will see that their fixed ideas, instead of varying with the circumstances—as they should if they were always in contrast with the present action—remain always the same in the same patient. Am. has only fixed ideas of suicide, Du. of homicide, Vi. of adultery, etc. That is because, in reality, the fixed idea is not brought about by the present action—it has a much more distant and much deeper origin.

(3) Although the fixed idea dates back further than the present action and is not awakened by it, one must not, for all that, trace it back to the very beginning of the delirium and say that the illness began with the obsessions. In reality, the patients have long been in doubt or in aboulia; they have long been impressionable, emotional, before being obsessed. Marcelle felt her hesitancy of will from the time of her convalescence following typhoid fever—that is, at the age of fifteen—and she did not begin to have fixed ideas until the age of nineteen. One therefore cannot say that these ideas are what provoke the hesitation of movements, since they are posterior to it by at least three years. In reality, the opposite is true—it is by seeing herself so hesitant and so powerless that Marcelle came to think of paralysis. All these negative commands that appeared during the crisis—"Don't speak, don't move," etc.—are nothing but the observation of the state of powerlessness in which the patient already was. Without a doubt, they increase the aboulia, but they did not create it. It is the same with other ideas of this patient, when she tells us that "her stomach is made of cardboard," that "a bad machine has been put inside her"; these ideas momentarily increase and define the digestive disorders and the refusal of food, but are themselves nothing more than the exaggerated expression of prior digestive disorders, of alterations in visceral sensations related to the typhoid fever, the subsequent emotions, and the aboulia itself. This is that pathological vicious circle on which I have so often had the occasion to insist.

Moreover, the interpretation of these relationships between aboulia and fixed ideas constitutes one of the most important problems for the study, classification, and treatment of mental illnesses. It seems to me that observation has shown that, in a certain number of cases, the aboulia is primary and chiefly affects the higher regions of action. It probably manifests above all as a more or less pronounced state of aboulia that exists initially in all patients. There are indeed cases—and we will see examples further on—in which the fixed ideas, which arose rapidly, constitute a more serious and more fundamental symptom and contribute enormously to reinforcing this very aboulia; whereas in others, the fixed ideas remain a secondary symptom added onto the aboulia, and this insufficiency of higher cerebral functions can persist entirely even after the disappearance of the fixed ideas.

To summarize this discussion, we believe that the fixed ideas do not yet provide us with the definitive explanation of Marcelle's aboulia. They form a new symptom, as it were a second degree of the illness, which is added onto the disturbance of movements. Just as certain movements—older, already organized movements—were automatic in her case and occurred without her present, powerless will being able to stop them, so too the old ideas, the memories once acquired, have become automatic and repeat themselves endlessly without current thought being able to stop them. This automatic reproduction of old ideas occurs in two ways: at times it is complete during a kind of crisis; at other times, it is incomplete and takes place during waking, when normal thought still partially persists. In the first case, these ideas alone dominate; they are accompanied by hallucinations that leave no room for doubt. In the second, these ideas come into conflict with present-moment thoughts and then provoke the doubts, discussions, and endless questioning that characterize this type of delusion. We have therefore observed in the intelligence a disturbance parallel to the one we had seen in impulsive and suggested movements; we must now see whether there does not exist another intellectual disturbance, this time parallel to aboulia itself, which may offer us a better understanding of it.

4 – The Perceptions

To properly understand a mentally ill woman, one would need to be able to review all her psychological faculties and determine exactly what, in each group of phenomena, deviates from the normal law—just as one examines each physical organ in order to understand an organic illness. Unfortunately, the investigative methods are still quite imprecise, and the normal laws of psychology are still general and vague; thus, this psychological analysis is necessarily reduced to a few isolated remarks, to a few approximate data points. However insufficient this inquiry may be, we must not neglect it.

A first hypothesis about the nature of aboulia will allow us to point out the state of sensitivity. Several authors—among them M. Ribot⁸—have attempted to link aboulia to a diminution of sensitivity, meaning by this not a disappearance of

⁸ Ribot. *Maladies de la volonté*, 1883, p. 50. Paris, F. Alcan.

sensations properly speaking, but a suppression of ordinary emotions and desires. “What is affected in aboulia,” writes this latter author, “is the affective life, the capacity to be moved. The patients do not carry out actions because they do not desire them sufficiently”.

(1) Is it not to be feared that these authors are being guided here by overly theoretical considerations? They seem to believe that affective states, emotions, are the only phenomena capable of producing movements, and when they observe a disappearance of movements, they immediately suppose a suppression of desires and emotions. We must remember that all psychological phenomena are psycho-motor, that a visual image, any thought whatsoever, can determine movements—and we should observe the facts without this preconception.

(2) In this explanation of aboulia, the authors seem to believe that this symptom manifests by itself. We have seen that, most often, aboulia is accompanied by numerous automatic movements, very strong suggestibility, fixed ideas, and impulses. If the absence of desire explains, at a stretch, the disappearance of voluntary actions, it poorly accounts for the impulsive acts that we have observed in such subjects. These cases do not seem to us to justify that assumption. I have learned at my own expense how emotionally reactive Marcelle is: a clumsy word, an indiscreet question threw her into despair; she cried the whole day and was angry with me for eight days because I had asked her what she drank at the table in her parents’ home. She has extremely sudden fits of anger that she cannot control, and she is timid—even fearful—to the highest degree. The affections she retains for certain people are as intense as her hatred for her parents.

(3) Finally, I observe in her all kinds of emotions and all sorts of passions. It is the same, moreover, for all the other patients of the same kind; they are not too little sensitive—they are almost always far too emotionally reactive. This trait, moreover, does not surprise us: the emotions are probably connected to that automatism of ideas and movements which is not suppressed here, but exaggerated. It is true that one will sometimes observe, in these patients, strange disturbances of emotion; they are at times as incapable of being moved as of acting. But far from preceding and explaining aboulia, this absence of emotion—when it does exist—is rather a consequence of it.

It is the intellectual faculties of these patients that seem much more altered; we have already seen this when speaking of fixed ideas, and we must return to it again. In medical examinations, one generally asks for an assessment of a patient’s intelligence; this question, always difficult, is even more troubling in the case of Marcelle. At first glance, one believes they are dealing with an intelligent person; she usually converses easily when she is not too intimidated, shows that she has received some education, and on certain topics—particularly when one speaks to her about her father—she shows delicacy in her judgments. But let us try to measure her intelligence using a criterion often employed. Let us examine what she has learned, what she has understood about the things happening around her. Let us question her particularly about her stay in the hospital. In a hospital—and especially in an asylum for mentally ill women—there are a thousand things

that should strike a young girl. The patients, the nurses, the doctor, the visits made to the wards—all of this presents a very varied series of scenes, and a person who has never seen anything of the kind should make numerous observations. We know that this is the case with ordinary patients, who, after just a few days, are thoroughly familiar with the hospital's organization and the members of the staff. Well, Marcelle astonishes us by her ignorance; she has been in the ward for a year and she has seen nothing, understood nothing. She barely knows the nurses who care for her and has not noticed their hierarchy; she has not remarked on any patient and has not learned more during her stay in the ward than an idiot might have. In a word, she seems to exhibit the results of a past intelligence, and not of a present intelligence. This strange form of intelligence will be explained by the following analyses.

The memory, in fact, presents a similar characteristic: when she recounts incidents from her past life, one notices that her narrative is clear, accurate, and rich in detail, so long as it concerns the years prior to age fifteen, the time when her illness began. From that point on, the memories become sparse and vague. But if one moves beyond the age of nineteen, the memories are nearly absent and limited to a few striking events. Finally, if she is questioned about the last months, the last few weeks that have just passed, one observes with astonishment a complete forgetfulness. The memories acquired long ago are preserved, but she has become increasingly incapable of learning anything new, of acquiring any new memory. This forgetting of recent events is very striking in its speed and depth: she is absolutely incapable of telling us what happened the day before; often, by noon, she no longer remembers the morning. A remark she made summarizes this situation: "Is it possible that it's already been a year since I entered the hospital—a strange year during which nothing happened!" It is, in a twenty-two-year-old girl, the memory of an old man who can recite the *Aeneid* but does not remember what he did in the morning. Marcelle has, for the past few years, been in a psychological state such that she is incapable of acquiring any new memory.

There are others affected by the same illness in whom one does not observe the same memory disturbance as in Marcelle. They do acquire memories, they do retain them—but they have a continual uncertainty about their memory and attempt to replace it. They constantly doubt their memories and do not seem able to fix them securely; and at every moment they come imploring others to confirm their faltering memory. This phenomenon is especially characteristic in J.; she always wants to be reassured and to have her memories guaranteed to her, even those she seems to possess. We believe that this memory disturbance, this doubt, is only the first degree of an alteration of which Marcelle presents to us the fully developed form. She must have experienced in the past—around the age of nineteen, though she no longer recalls it—doubts analogous to those of J. A patient whose case M. Séglas communicated to us can serve as an intermediary between these two subjects. He sometimes has doubts about the memory of recent events, and sometimes complete amnesias. It is useful, in order to understand the attenuated form which is doubt, to first examine the complete form, which is the type of amnesia described in Marcelle.

The complete form, which is the kind of amnesia described in Marcelle, is also observed in relation to our patient's imagination. She appears to be totally deprived of it and is in no way able to represent the future. "I feel stunned sometimes," she tells me when I try to find out what she thinks will happen to her later; "I cannot know what will happen." This phrase, which she often repeats, should not be taken as the expression of reasonable fears about the future. She imagines no danger; she is simply incapable of conceiving that she might again live with her parents or that she might live in the hospital; the future is, for her, a black hole, which she cannot fill with any image. Another patient, on the contrary—Ara.—also offers us the first degree of this same alteration; she represents the future to herself, but without precision, without fixity, and so she doubts all of her representations: "You say that I'm going to leave tomorrow—yes, I think I'm going to leave, but it's not certain, I think I'm going to stay in the hospital... Will I walk in the street?... I'm not very sure that I'll walk there... I'll look out the window, but it seems to me that I'll throw myself out the window. Well, no, I'd rather stay at the hospital: here, the windows are barred and they watch us—they won't let me do anything foolish; I need that, because I'm not sure what I'll do tomorrow." Here again, Marcelle is at the extreme degree of the illness.

We will nevertheless find these doubts even in Marcelle, if we examine in her some more elementary operations which, at least at certain times, are a little less impaired. One knows the role that the idea of personality plays in normal and pathological psychology, the operation of personal perception. Well, this patient does not manage to understand herself and doubts her own personality. "Am I really Marcelle?" she says to me, in several conversations from which I am copying the main phrases, "It astonishes me, because I do not recognize myself; ... no, I am changed; ... it's not me; ... they've done me wrong, they've put a cardboard stomach in me... The real Marcelle is lost, I no longer know where she is, but if I ever meet her, I'll show her to you so you can see that she is better than me." However, if one insists, she acknowledges that she knows all of Marcelle's secrets and that Marcelle's father is indeed her own. We see from these examples that she has indeed preserved the notion of her past personality, but that it is always her present personality that she does not understand: "It's strange," she concludes, "am I Marcelle or am I not?" This is doubt in present personal perception; a few days later, in a moment when the illness is more severe, we will see the disappearance of this perception. She no longer knows what she is and laughs stupidly when asked; she is entirely occupied by the dominant fixed idea and has only images related to that fixed idea. There is, in her, neither one nor two personalities at that moment; there are an infinite number, as many as there are fixed ideas or artificially provoked psychological states, none of which are connected to one another.

Finally, it is easy to observe analogous disturbances with the same degrees and the same variations in the perception of external objects, but since they then present themselves in a manner more accessible to study, we have noted them with more detail. Indeed, Marcelle herself came to draw our attention to the changes she was feeling and evaluating in herself. "Things are not as they used to

be; I can no longer perceive clearly what is happening around me; it all seems like a dream; people don't seem real anymore." One day, she was attending a little concert that is occasionally given to the patients in the asylum for their amusement. She turned to me with the strangest anxiety and asked: "Is all this really true? The music, these people dancing—this can't be real. It must be a play." These are curious remarks, but not very intelligible at first. What does she mean, and what is happening in her mind? This has already been observed quite often in aboulic patients and in the madness of doubt. But I think Marcelle's case is particularly interesting and useful here. Indeed, she is not very intelligent, she is not reading at the moment, and she is not inclined toward psychological subtlety. Many patients, while feeling as she does that objects no longer seem to be real, engage in endless metaphysical discussions of the kind Legrand du Saulle has reported in several examples. Consequently, the observer no longer knows exactly what to attribute to the disturbance of perception and what is due to the fixed ideas. M. Paulhan has also come to believe that patients have a fixed idea of negation of the external world and that this idea arises in contrast to present perceptions. In Marcelle's case, nothing of the sort. She reserves her psychological ruminations for the romantic stories related to her birth and her parents; never has she done metaphysics about the external world. It is certain that she has, neither during her clouded crises nor outside of them, any fixed idea concerning the existence of the external world. She does not for a moment consider denying the existence of objects, for she herself says: "I know very well that these people exist, but they don't look real." Here, the doubt in perception exists on its own, without any complicating mixture.

We must, in the delusions of doubt, make a distinction analogous to that which we made earlier in the delusions of contact. Some of these delusions are primary, and they are then limited to a specific object upon which the patients ceaselessly ask themselves questions. "What is God? Why are trees green, etc.?" This is an interrogation, a discussion consecutive to a fixed idea, such as we have observed in Marcelle upon waking from her crises. This is not doubt properly speaking. One is not a doubter because one asks whether God exists. Delusions of doubt of this kind are sorts of fixed ideas. But there is a delusion of doubt of another kind that is too often confused with this one: it is a true universal doubt bearing upon all the psychological phenomena of the subject; just as the general delusion of contact seemed to us to follow motor disturbances, this form of delusion of doubt seems to us secondary and consecutive to certain perturbations of memory and perception. Many questions, often endlessly debated, could, we believe, be easily settled if one kept in mind this distinction. People often ask whether the delusion of doubt and the delusion of contact are two different delusions or two delusions that depend on one another. If we take these two delusions in their form as fixed ideas, they are independent, for they are two different fixed ideas that chance will not always make coincide. But if we consider these two delusions as alterations of motor phenomena and of perceptual phenomena, we will see them almost always run parallel. For the examination of doubt in our subject will show us that the alteration of perception is entirely analogous to the alteration of will already studied.

To what phenomenon can we link all these alterations, which always retain a certain analogy with one another and which appear in memory, imagination, personal perception, and external perception? The first and most natural supposition is that the sensations are altered; anesthetics are frequent among hysterics, to whom Marcelle resembles in many respects, and a disappearance or diminution of sensitivity due to exhaustion of the sensory centers might perhaps account for at least part of the observed alterations. Unfortunately, the case we are studying does not seem to lend itself to this simple explanation. Except in certain exceptional moments, I have not been able to observe any anesthetics. Tactile sensitivity was at times altered in the final period of my observation, especially following suggestions and specific treatments, which I will discuss shortly, but for several months, at the beginning of my research, during which I observed all the previously mentioned phenomena, it was never diminished in any part of the body. Measurements made with a compass gave results that were very similar to those obtained in normal subjects who are not well accustomed to experimental procedures, and who do not pay much attention. I was especially focused on studying muscular sense in this patient, because the disturbance in her movements led me to suppose a disorder in that form of sensitivity. One might suppose, as Dr. Bastian does in his interesting book *The Brain as an Organ of Mind* (1880), that there existed in such cases a central exhaustion of kinesthetic sensitivity. Since Marcelle did not present any clear or severe muscular anesthetics and could always distinguish, with eyes closed, the passive movements communicated to her limbs, I very often repeated on her a more precise experiment indicated by M. Beaunis.⁹ While Marcelle had her eyes closed, I guided her right hand, which held a pencil, to draw on paper a straight line, an angle, or a curve, and then I asked the patient to reproduce on her own, without opening her eyes, a line of the same size, a figure of the same shape. These reproductions were made by Marcelle with great precision, and her errors were far below those one might expect from a normal person. The difficulty she experienced in performing this experiment depended, as always, on the hesitation of her movements, and not on the absence or forgetting of kinesthetic sensation.

The study of hearing did not reveal any interesting modification; the examination of vision shows a certain decrease in the visual acuity of the right eye, but this decrease disappears with the use of corrective lenses, and overall visual acuity is normal; color vision is accurate, and the visual field is not constricted.

It would be very important to be able to conduct a study just as precise on the sensitivity of the mucous membranes and on visceral sensations. The modifications of personal perception suggest modifications of coenesthesia. This has been well established by M. Ribot, and it is commonly accepted in melancholic delusions and in various disturbances of personality. Moreover, when Marcelle tells us repeatedly that ‘she has a cardboard stomach and a very poorly made machine in place of a heart,’ one may wonder whether these ideas are

⁹ H. Beaunis, *Recherches sur la mémoire des sensations musculaires*. *Bulletin de la Société de psychologie physiologique*, 1888, p. 29, et *Les sensations internes*, 1889, p. 133. Paris, F. Alcan.

merely consequences of delusion or if they are not the interpretation of disturbances in sensitivity. This is the remark I have already made concerning the ideas of paralysis that I connected to aboulia. Unfortunately, a precise examination of visceral sensitivity is extremely difficult, and one must be wary of the assumptions we are too inclined to make for the sake of theory. All I can ascertain is that everywhere the mucous membranes are accessible, they appear to be perfectly sensitive; Marcelle claims to feel the passage of food and seems to experience visceral needs normally. She has often complained of not being able to eat her fill or drink to her thirst because of her hesitations and fixed ideas. It is true that she very often has headaches and complains a great deal of a sensation often referred to as a 'hysterical nail,' that is, a severe pain at the vertex, along the midline, a little behind the frontal region, and a little in front of the bi-auricular line. We saw that to describe this pain she used an expression which, for her, was not just a metaphor but turned into a fixed idea: she claimed to have a beast in her head gnawing at her brain. This pain, with its specific location and form, seems to have a close relationship with this illness of aboulia and fixed ideas, for I have consistently observed it in patients of the same type. Several of them, like Justine and Maria, who will be discussed later, used the same expressions to describe it and also complained of the beast in the head. This pain is obviously a disorder of cerebral sensitivity. But how can we prove that this disturbance of such an obscure sensitivity is the starting point of all the other cerebral phenomena, and how can we demonstrate that it is not simply the consequence of an actual alteration of the brain itself—and in particular of the underlying frontal lobes—an alteration that would determine the other disturbances and incidentally produce a cerebral pain, as happens in any organ that functions poorly? In a word, if this patient presents anesthetics, they are very minimal and inaccessible to our clinical measurements, which is why I hesitate to explain the disturbances she presents as alterations of sensitivity, as I did in the past in my book on psychological automatism, when I attributed amnesias and paralyses to anesthetics.¹⁰

We must therefore be led to seek a better explanation; this investigation is all the more necessary because Marcelle's case is far from isolated. It has often been noted that aboulic or doubtful patients are far from always presenting a sufficient lack of sensations to explain all their disorders. They say that they hear through a wall, that they see through a shutter, and one very often finds their hearing acuity and visual acuity to be absolutely normal. It is necessary to conduct other kinds of studies on these patients. Mental activity begins in sensations, but it does not stop at sensations. For a person to think and act, to remember, to have perception of their own personality and of the external world, it is not enough for them to experience and retain isolated sensations—these sensations must still be associated and combined as raw material to be worked into something. There are other functions in the mind than pure and simple sensitivity. In the cerebral cortex, there are centers of association just as there are sensory centers, and even

¹⁰ "Here again, I said previously, disappearance of sensitivity, disappearance of memory; persistence or return of sensitivity, persistence or return of memory. Sensory activity forms the basis of thought; when it is extinguished, thought disappears or falls asleep." *Psychological Automatism*, 1889, p. 102. "There is never anesthesia or amnesia without a corresponding suppression or modification of movement." (*Ibid.*, p. 364).

within the sensory centers themselves, there must be a processing of sensations so that they are not left isolated. It is this power of combination and construction that we must now attempt to study in Marcelle's thought, by examining with greater care the disturbances of perception she presents.

This phenomenon can, in fact, be easily studied in Marcelle. As she is very ill, she never displays symptoms halfway; she soon pushes them to their greatest exaggeration and presents them in a much clearer manner. One day, when Marcelle's parents came to visit her, it was thought that granting her permission to leave the ward and take a walk in the park of the Salpêtrière would please her.

However, she had to be brought back shortly afterward due to a strange incident. Once outside the buildings she was familiar with, she began to look all around with a frightened expression, asking: "Where am I? What is this? Who is there?" She no longer wanted to walk forward and was feeling the ground to see whether it was solid or not; she could no longer recognize any object—not even a tree or a bench—and ended by saying that she could no longer see clearly. Once she was returned to the familiar ward, she gradually recovered and recognized the objects around her. Her doubt regarding external perception had turned into an absence of external perception.

In another situation, when Marcelle was very ill and in the grip of delusional ideas, she demonstrated a similar disturbance—not this time in the perception of visual images, but in the perception of auditory sensations. She seemed to listen to what was being said to her, but instead of saying, as she usually did, that she could not believe, she began to laugh and repeated: "What are you saying? But I don't understand you." She was no longer able to understand a single word.

These latter facts are all the more interesting in that they can be reproduced experimentally. If you show her objects—a book, a knife—and ask her what it is, she cannot, on certain days, affirm their nature with conviction: "I think it's a book, but I might be wrong... Let's see, you say it—do you think it's a book?" In another patient from the ward, a rather peculiar melancholic, E., this symptom is constant. When you show her an object, she says: "It's a bed, I think; it's a hand, it seems to me." She is never sure of what she sees. But in Marcelle, the phenomenon goes further, for one can also reproduce not merely doubt, but an actual absence of perception. This is very easily and almost always demonstrated by asking her to read a few printed lines. It is a curious sight for a psychologist—the way Marcelle reads a newspaper. I point out a paragraph and ask her to read it. She obeys and seems to read it silently: "It's done," she says.

"Good, what did you read? What is it about?"

"Well, I don't know. Let me read it again." She rereads it silently.

"Well?"

She seems surprised: "But," she says, "I don't know what it's about. It doesn't go into my head."

"Read aloud."

She reads aloud and very correctly, though in a monotone voice. But when she has finished, the result is the same: she did not understand what she had just read. It is as though she were reading in a foreign language; she pronounces the words,

she understands each one individually, but absolutely nothing of the whole passes into her thought. The sensations are clearly not lacking, since she reads aloud correctly. Nor is it merely a memory deficiency. Once, immediately after reading aloud, I asked her to recite the words contained in two lines. She was able to recite them almost all—but without understanding the sentence. This recitation of words was not even in the order of reading, but seemed to follow the order of banal associations. She recited together words with the same consonance or of the same kind. One day she read a short paragraph about a fire that included several numbers: the date, the number of houses burned, the number of victims. She recited to me, one after another and without error, all the numbers in the paragraph—but without understanding what they meant. One sees that this intellectual alteration concerns neither sensation, nor memory, nor the association of ideas in the usual sense of the term.

In seeking to vary the phenomenon, I gave her things to read that were increasingly simple, just simple sentences of a few words; she sometimes managed to understand them, but then fell back into her usual doubts: “Is this it?... It’s this, if you say so.” The complexity of the sensations to be understood thus plays a role here. But the main condition lies elsewhere. I had her read a paragraph from a newspaper announcing the marriage of a very well-known person and describing the ceremony. After she had read it aloud, I tried to help her understand what it was about. Since she understands spoken language better—especially mine—she eventually managed to grasp it. The next day, I first had her read a different paragraph; she understood nothing. Then, without warning her, I put before her the same paragraph explained and understood the day before. She read it aloud and exclaimed proudly: “Ah, but it’s the marriage of Mr. X..., and the ceremony at the church... You see how well I understand now.” I was able to repeat this little experiment over several days: any random article, even just two lines long, was never understood. But when she read *her* article, she triumphed—without herself realizing the true reason why she understood it so well.

This reason, as we have clearly seen, was that the article had already been understood once, and the other articles were not understood because they were new. To understand what one reads, one must carry out in the mind the synthesis of the different visual sensations, and when it is a new book, it is evidently a new synthesis. The experiments show us that although the complexity of the synthesis plays some role in disturbing Marcelle’s mind, it is above all the *novelty* of the synthesis that completely suppresses perception. When this synthesis has once been made by any means whatsoever, it is then repeated automatically. The elements no longer need to be linked—they are already linked; it is no longer a synthesis but an association of ideas, and Marcelle performs this very well, without hesitation and without doubt. We have already insisted several times on the distinction—essential in our view—between these two operations: the present observation confirms it again, by showing us that one of these phenomena can be preserved, while the other disappears.

The preceding observations are clarified by this remark; we understand why Marcelle knows perfectly well where she is and does not even doubt the reality of objects when she is in the infirmary; why she doubts when she goes to a concert

in a room of the same ward, and why she no longer understands anything at all when she goes into the park. Many observers have noted, in the madness of doubt, this strange way of perceiving things: “She asserts,” says one of them, “that she feels in the state of a person who is neither dead nor alive, who lives in a continual sleep, and to whom objects appear as if wrapped in a cloud; to whom people seem to move like shadows, and words seem to come from a distant world.”¹¹ M. Ribot, who quotes these words, explains this state by a disturbance in the emotions; we believe we have shown, by considering the stronger and clearer degrees of the same illness, that it is a disturbance of perception—whether personal or external—and that this disturbance is due above all to an *inability to synthesize new impressions, whether they come from within or from without*.

The previous conclusion immediately brings to mind another quite similar one that we had reached at the beginning of this chapter, when we were analyzing not the ideas but the movements of Marcelle. The study of her intelligence leads us back to the same conclusion as the study of her movements; it could even be shown elsewhere that the disturbance of intellectual functions is parallel to the disturbance of motor functions. Thus, we are inclined to believe that it is this general psychological fact that constitutes the principal disorder of our patient and that it is possible to relate all the symptoms to this central fact.

Let us attempt now to verify the analysis, and let us take as our starting point the deepest psychological disturbance to which we have arrived, and show how it leads in turn to all the characteristic phenomena of the delusion of doubt, aboulia, obsessions, etc. But since it is not our intention to undertake a study so general, it will suffice to show how this principal notion, this guiding idea, allows us to understand the symptoms—at first glance so complex—presented by our patient.

In my earlier studies on hysterical patients, published by the *Revue philosophique* in 1887–89 and in my book *L'Automatisme psychologique* (1889), I had shown that, by various methods—and in particular by exciting and directing attention—one could temporarily restore all sensitivities to anesthetic patients, and I had studied the curious consequences of this return of conscious sensations for memory, movement, etc. I sought to determine whether something similar could be done with Marcelle—not to restore sensations she had preserved, but to momentarily increase, in a notable way, her exhausted strength, that psychic activity, whatever it may be, that allows us to synthesize and understand elementary phenomena. I observed that, to achieve this result with this subject, it sufficed to put her into a deep sleep, up to a certain point which I could recognize in practice by the onset of contractures in the limbs, then to leave her completely undisturbed for half an hour—or better, an hour—avoiding any speech. It then sufficed to wake her with the usual precautions. I do not study here the very curious effects of prolonged sleep in these patients, which I have often discussed; I merely note the psychological modifications it produced in this aboulie patient. Upon waking, she was transformed: her expression open and intelligent, her eyes mobile and capable of fixing on people, her movements quick—everything signaled the sought-after change. Marcelle herself was well aware of this state and

¹¹ Ribot. *Maladies de la volonté*, 1883, p. 51. Paris, F. Alcan.

called it a *clear moment*; it was a kind of remission in the illness, a moment during which the brain, in a sense rested, resumed its normal functions. This curious phenomenon plays a fairly important role in the illness. I have observed it under various circumstances, with greater or lesser clarity and above all with greater or lesser duration, in all aboulie patients. It corresponds to the state I described under the name *complete somnambulism* in hysterical patients—a state during which the patients momentarily recover all their sensitivities, their memories, and their movements. This state is in reality, as I have repeatedly said, nothing more than a momentary reappearance of the subject's normal waking state, a state which takes on the appearance of somnambulism "because of the collapses, the returns to the anesthetic state."¹² These clear moments, in Marcelle's case, were fairly short, and I was never able to prolong them beyond a few hours. But although they did not offer significant advantages for treating the patient, they presented great interest for study, by allowing us to examine, just hours apart, the same subject alternately sick and momentarily cured.

During these clear moments, sensation itself was not modified—it remained normal, as before—but external perception appeared completely transformed. This person, who paid attention to nothing and barely understood where she was, suddenly changed character, examined everything clearly; more than that—what is extraordinary in her case—she showed signs of great curiosity: "Oh! there's a cabinet here, let me see what's inside... Oh! you have a bell cord there..." In a room she had entered a hundred times without seeing anything, she made a number of wonderful discoveries. Needless to say, she recognized without hesitation or doubt the objects I showed her, and she understood more or less what she read, provided it wasn't too complicated. In a word, we see that she was able to form in her mind the synthetic representations necessary to perceive unknown objects. And at the same time that thought returns, we see all the faculties reappear, all the morbid symptoms lessen or disappear.

Internal or personal perception, the idea she has of her own personality, becomes normal again. She recognizes herself, admits to being Marcelle and no one else; she reconnects within a single self the sensations she experiences in her body, the notion of her present situation, etc., to the memories from her youth. In a word, personal perception behaves like external perception.

This change is going to have a rather unexpected result: it will reestablish memory or the ability to acquire new memories. The memory of the previous days is not restored in her during the lucid moments; it seems that since these memories were not acquired, they cannot be retrieved, even by a more capable mind. But the memories acquired during these lucid moments will have the property of being retained. An example will make our observation clearer. During one of these moments, upon awakening from somnambulism, Marcelle notices on the table pieces of metal—fragments of a dismantled electrical apparatus. She is concerned about these pieces of copper and is not satisfied until I have explained their use to her. Shortly afterward, she falls back into that dull state which is habitual for her. Eight or even fifteen days later, I only have to ask her what she saw with me in the office for her to describe exactly the fragments of the

¹² *Automotisme psychologique*, 1889. p. 114, 121, 126, 134, 178, etc.

electrical apparatus. On the contrary, all the events that occurred in the interval, even striking ones like a visit from her parents, or very recent ones like the events of the morning, were completely forgotten. Thus, it is indeed the alteration of perception that is the cause of the subsequent memory defect. And moreover, we insisted on verifying the fact through observation, but one could have predicted it by reasoning. Memory is not solely the conservation and reproduction of images; it is above all the conservation of an order, of a grouping of these images—in a word, it is only the conservation of a synthesis previously formed. It is clear that memory will not exist when the synthesis has not been formed or when it is only half-made and remains unstable and fragile. Memory is a bodily function; memories are in a way incorporated into the organism, without any doubt—but they still must have been organized. To establish memories, to create habits, to build the organism—these are all phenomena of the same kind; they are prerogatives of mental and vital activity.

We can now predict that during these lucid moments, the movements will follow the general improvement and that the aboulia will disappear. If Marcelle has managed to read two lines that she did not know and if she understood them well, there is no need to verify the state of her movements; I can guarantee in advance that they are correct and that she takes a new object without hesitation. Indeed, I have always seen these two phenomena run parallel; and little by little, in examining this patient, I have come to link these two seemingly different things. External perception and the volition of movements are, at bottom, one and the same thing—a single mental operation. In both cases, psychological elements are supplied: visual sensations on the one hand, kinesthetic images on the other; in both cases, it is necessary to synthesize them and to relate them to the total set of other ideas already acquired. The operation remains of the same nature. No doubt certain people may find it more difficult to operate on particular groups of sensations or images. I had noticed at the beginning of my studies that Marcelle moved more poorly when her eyes were closed and that she directed her movements better if she looked at her limbs, and at first I believed in an alteration of muscular sense, a condition affecting only the kinesthetic images, similar to Lasègue's syndrome. In reality, it is only a question of degree: Marcelle generally synthesizes auditory impressions fairly well; she must be very ill in order not to understand what is said to her, though that does happen sometimes. She synthesizes visual sensations less well and rarely manages to understand what she reads; and finally, she synthesizes even more poorly the kinesthetic images which, in her case, are especially involved in movement. Thus, the disorder of her voluntary movements is the most apparent. This distinction may be important in other patients, when the delusion of doubt particularly affects certain elements; but in Marcelle's case, it is only secondary. In movements as in perceptions, the disorder is the same: it concerns the formation of new syntheses, not the retention of old ones.

The preservation of previously organized groupings once formed explains the last symptom of the illness—fixed ideas—and links this phenomenon to the previous ones. These latter phenomena vary with circumstances and disappear completely during the lucid intervals. The strength of these fixed ideas arises

precisely from the weakness of newly acquired ideas at each moment. It is through our present thoughts that we hold back the rising tide of our suppressed memories; this present thought is the antagonist, and our old memories tend to reappear, to combine in a thousand ways, easily, automatically, and irresistibly. The memories, the repetitions of words, the daydreams lie just beneath our consciousness; a single moment of distraction is enough for them to reemerge, a moment of sleep is enough for them to flood the whole mind during dreams and nightmares. Well, Marcelle's mind is almost always asleep; she reaches at best that phase of half-wakefulness during which one moves poorly and perceives vaguely. It is entirely natural that she should have dreams and nightmares, and that these phenomena should follow in her the regular laws of automatism, of which suggestion has given us examples. It is enough for her to wake for a moment, to recover clear perception of new things and of her own changes, for all these phantoms to vanish.

Everything thus holds together in this illness, because everything is impaired in the same way; this thought of M. J. Falret on reasoning madness is thereby justified: "In this madness, clinical observation shows that there is indeed a predominance of the action of the moral or instinctive faculties, but not a complete absence of disturbances of the intelligence."¹³ And we may say with the same author that there is no monomania without an alteration of the entire mind.

There is no monomania without an alteration of the entire mind.

As for the very nature of this general alteration of thought, we do not claim to describe it after having analyzed only a single subject; we can only note here and there a few facts that may, later on, be connected with others. We have just seen that this state of mind is not without resemblance to a state of drowsiness or sleep; this is only an instructive comparison, not an interpretation. This weakness of thought also bears some relation to fatigue, as noted by M. Féré, or at least it is worsened by the slightest mental effort. I particularly remember one fact that struck me. Marcelle had just awakened from somnambulism and was fully enjoying one of her clear moments. Her mental state was remarkably good and, based on previous observations, should have maintained these qualities for at least half a day. Unfortunately, Marcelle, with that strange curiosity that only appeared during these moments, began to look at the papers on the table. She saw some sheets on which I had drawn visual fields and expressed the desire to know what all those little circles meant. Allowing myself to be drawn in, curious to see how a person of this kind would listen to a scientific explanation, I told her as simply as possible what a visual field was. To my great surprise, she understood quite well and began making fairly accurate remarks about the drawings she was seeing. All of this was too much for her—she stopped in the middle of a sentence, fixed her eyes on the floor, and entered into a major clouded state that lasted until the next day. A bit of mental fatigue had destroyed in an instant all the progress that had been so painstakingly achieved.

One can also connect with this mental state certain changes in physical health. The analysis of the urine provides us with a few observations worth noting: M. Bourguignon, an intern in pharmacy, kindly agreed—something for which I thank

¹³ J. Falret, *Études cliniques sur les maladies mentales*, 1890, p. 477.

him—to conduct this analysis over six consecutive days and found a certain reduction in all elements:

Average of 6 urine analyses, over 24 hours, the patient's weight is 70.5 kg.

Volume	712
Urea	20.97
Phosphates (Ph O ³)	1.927
Ratio between earthy and alkaline phosphates	20.4
Fixed residue	<u>100</u>
	61.29 per 1,000

One also notes circulatory disturbances: the hands are frequently cold and swollen; the feet have a livid coloration, they seem frozen, insensitive, as if dead, recalling somewhat the characteristics of 'blue edema.' There is also a bizarre curling of the fingernails on the right hand. There are also regular eruptions on the scalp and arms; these eruptions are now almost completely gone and consist only of small whitish plaques that flake off. Digestion is reported as extremely difficult, even though the patient eats very little. Finally, sleep is greatly diminished. Curiously, Marcelle's sleep behaves in the same way as her movements and thoughts. She very easily falls into a state of suggested (hypnotic) sleep but cannot manage to fall asleep voluntarily; hence perhaps the effectiveness of artificially induced sleep. In a word—without going into further detail—there is a reduction in vitality alongside a reduction in mental activity.¹⁴

The will, as a power of mental synthesis, seems to correspond to what, for lack of a better word, we call life — that power of construction and growth of the body. There must exist in the brain — perhaps in Flechsig's association centers, perhaps in the layer of tangential fibers of the cortex — regions that are in continual development, in continual construction throughout life, and a halt in this construction, in this evolution of the neuron's extensions, must correspond to the phenomena we have observed in aboulia.

From this description of the physiological and psychological doubles, let us retain only one thing: we observe in the intelligence a disorder analogous to that which has been observed in the movements; memory and perception, both external and internal, are impaired in an aboulic. This would justify the opinion of psychologists who claim that the will plays a role in intelligence. To our mind, it rather proves that the will, considered as the faculty to set the limbs in motion, and intelligence, considered as the elaboration of sensations and images, contain common elements. These common elements cannot be impaired without disturbing both functions: will and intelligence. This common element is here the elaboration, the synthesis of psychological elements made at each moment of life in a new way; it is the adaptation of the being to its environment, to circumstances. It is this which, in a normal mind, forms the perceptions of new objects, allows one to understand the new modifications of personality, lays the

¹⁴ Other patients of the same kind, whom I cannot study here, have presented much more serious modifications of nutrition. I have observed in particular, on a subject studied with Mr. Ch. Richet, not only an enormous reduction of the elements in the urine, but also a considerable change in the chemical phenomena of respiration.

foundation for future associations of ideas and memories, and finally arranges movements in a new way so as to produce actions that have not yet been performed in exactly the same manner. Let this activity — which seems essential — be impaired, and we have the intellectual and volitional modifications that we have just studied. Mental illness has revealed a psychological characteristic, an activity whose importance we might not otherwise have suspected.

5 – Evolution of the Illness

All the symptoms being known, we can now better understand the nature and the evolution of this mental illness.

Typhoid fever delivered a fatal blow to this intelligence, already evidently predisposed by hereditary antecedents, and brought about a fatigue or general weakness of the brain and consequently a reduction of thought. This weakness affects neither the senses nor memory properly speaking, as the faculty of reproduction of images; it is a diminution of that force of adaptation to events which allows us to remain in rapport with changes in the environment, with incessantly modified impressions. This weakness manifests at first through fatigue, sadness, the impossibility of learning and even of reading, the fear of strangers who require greater effort to be understood, the love of retreat, of isolation, and solitary reverie. The weakness of synthesis and of adaptation, gradually increasing, leads to greater and greater difficulty with all new phenomena, with perceptions that become doubtful, and above all with voluntary mental operations which become almost impossible. On the other hand, certain automatic reveries maintain a number of preferred dreams that more and more take on for her an air of reality, of force, of spontaneity, still mixed, however, with doubt and abulia.

The patient being definitively fixed in a pathological vicious circle, and becoming more and more confined to her dreams, is it possible to do anything to awaken her and bring her back into the world of realities? Physical treatments have had only a very weak effect; medications of all kinds, bromide, which was overused at the beginning, bring about no change. Electrical treatment should, I am inclined to believe, accomplish something. But one must admit that, in the present case, it was useless. Marcelle went three times a week to a session of static electricity, and I several times examined her mental state before and after the session; the modifications in her power of perception could be considered as a sign, a reagent, indicating precisely even the smallest progress; well then, there was never any progress after an electrical session. On the contrary, showers have a visibly favorable effect: after a shower, Marcelle sometimes had a moment of clarity, like after a deep sleep, but of very short duration.

One would obviously need to be able to resort to moral treatment, which is the only true one when it is a matter of illnesses that are moral; unfortunately, we know so little about psychological facts and laws that we cannot institute any reasoned treatment; one is forced, as in the beginnings of physical medicine, to proceed by trial and error, and one must not be surprised if the results are uncertain and mediocre.

Convinced, as I was, that Marcelle's illness was due above all to a weakness of attention and of the activity of synthesis, I first sought to determine whether it might be possible to develop this activity simply through exercise. I wanted to force her to work; I brought her books; I suggested small attention exercises, I wanted to train her to perform voluntary movements in front of me and I obliged her to look at her hands, to mentally visualize their movement in order to reinforce, through visual images, the insufficient kinesthetic images.

Marcelle was unable to do any of my exercises; she read when I forced her to, but in the manner I have described—that is to say, without understanding a word. The movement exercises using visual images had a strange and rather negative result. Indeed, the movements were performed somewhat better, but the arms and hands became totally anesthetic; in place of the distraction and abulia characteristic of psychasthenia, I was unknowingly developing hysterical anesthesia. Marcelle, who during an observation period of five months had never been anesthetic, became so when I tried too strongly to modify the distribution of her attention, or, if one prefers, of her nervous force. The fact is very interesting for theory—it shows us the relations between these two illnesses, the connection between distraction and anesthesia, which I had already often studied—but it did not seem useful for the patient. Something else had to be tried.

I thought that the fixed ideas which obsessed the mind and diverted all its force to their benefit were the principal obstacle to the development of attention. Since this patient was easily hypnotizable, it was natural to attack the fixed ideas by means of suggestion, as several alienists have already attempted. But this procedure can be convenient when the patient has only a single fixed idea and when the mind, not yet too weakened, can regain its power as soon as it is freed from the obsession. With Marcelle, this attempt presented a host of difficulties and endless work.

At the beginning, everything went very well; I addressed the ideas of which Marcelle was complaining at that time. These were for the most part visual hallucinations which I have described. A few suggestions easily overcame them. There was especially one terrifying hallucination, a gloomy tableau that Marcelle constantly saw before her eyes. I managed to transform it so well, by mixing in other hallucinations, that the subject ended up no longer recognizing it, and I was then able to eliminate it without difficulty. I was already congratulating myself on this fine result when I was struck by a phenomenon that made it insignificant: Marcelle, freed from this fixed idea, was for the moment very happy, and she awoke from the somnambulistic state in a remarkable condition. She asked, with astonishment, "How did you do that to me?" In short, she entered into what we must define as a clear moment, and this fact is important for showing that the fixed idea, although superimposed upon the abulia as I have shown, contributed to its development. The change took place in the morning; she spent the afternoon in this good state, but in the evening, usually around four o'clock, there suddenly came a crisis of anguish after which Marcelle returned as dark as the day before, prey to a new fixed idea. I remember having once studied, at the hospital in Le Havre, a hysterical woman who had both legs anesthetic and contracted in

extension. I succeeded, though with difficulty, in decontracting her legs during a complete somnambulistic state induced in the morning, by forcing her to pay attention to her legs, to recover their conscious sensitivity. But in the evening, a hysterical crisis occurred, and regularly I would find the patient the next morning with both legs anesthetic and contracted. Marcelle behaved in the same manner with her fixed ideas and imposed upon me the same endless labor.

I then noticed with dismay that the new fixed idea, which thus came to replace the one I had removed, was always much more tenacious than the previous one. Instead of yielding after a few sessions of somnambulism, it lasted a long time, disappeared only in part, and reappeared regularly every evening with scarcely diminished violence. Moreover, the subject, during somnambulism, resisted more and more in order to defend her fixed idea; she now seemed to realize what I wanted to do and struggled desperately. Each somnambulistic session became a kind of battle, from which I did not always emerge victorious. If I succeeded, the awakening was good, and Marcelle had a clear moment; if I did not succeed, the awakening was bad, and Marcelle was as tormented and as abulic as before.

Several ideas had already apparently disappeared definitively—the gloomy hallucinations, the blow to the head, the hatred of her parents, the substitution of children, etc.—and I had reason to hope that this succession of absurd ideas would not be eternal, when there arose a much more serious fixed idea which caused us great trouble. Since she had been at the hospital, Marcelle had eaten properly and even told me: “At home, I couldn’t eat at all; here, the food isn’t as good, and I eat anyway—probably it’s the showers that give me an appetite.” Around the middle of June, she began to feel, during the clouded states, an inner voice which, giving up speaking about the parents, their hatred, etc., murmured: “Don’t eat, you don’t need to eat.” Marcelle herself confessed this to me during a somnambulistic state; I became worried and immediately tried to oppose this fixed idea, which I judged dangerous. At first, everything went well: the voice disappeared at my mere command. But it reappeared the next day. A new suggestion from me was more difficult for the subject to accept in somnambulism. In the evening, Marcelle was very distressed when she wanted to eat; she felt within her a voice saying: “Don’t eat,” and at the same time heard a voice, sounding like mine, saying: “Eat, I want you to eat.” She hesitated but ended up obeying the good advice. However, the situation worsened; the suggestions became increasingly difficult, the subject accepted all hallucinations, all transformations, all possible suggestions—provided that she did not see the obligation to eat arising in the distance. Then she became obstinate, repeating: “No, no, I don’t want to,” and nothing more was possible. One day I tried having food brought and making her eat in front of me; it was a scene, but she ate. The next day, this method was already less successful; strangely, she ate unconsciously when I spoke to her about something else and did not want to eat consciously. We have already explained how this phenomenon must be understood: Marcelle’s personality is extremely subdivided; each fixed idea forms a kind of person that has no thoughts, no memories outside of the dominant idea. When one is in the presence of one of these groups, whatever it may be, all other thoughts have become subconscious. Finally, one day she resisted even more than

usual, and I asked myself whether I should continue to fight by suggestion when I could perhaps provoke the automatic state by other means.

The illness that held Marcelle in its grip had to be forced to define itself and to reveal itself in this person through some manifestation. It was necessary to push her to act against herself, and I tried to follow this path. In the midst of her resistance, Marcelle suddenly let go, fell into contracture, and quite simply began a hysterical attack. The attack was absolutely normal and classical: the suffocations at the beginning, the convulsions, the salutations, then the cataleptic poses in which she held her arms in the shape of a cross and repeated movements she had seen done in gymnastics—all these phenomena followed one another regularly. This attack, which lasted two hours, is interesting for characterizing the state of our subject and justifies the comparisons we have often made between her clouded crises and the complicated crises of her illness with hysteria. One might say that she is a psychasthenic and abulic patient who also has hysteria. That is not our opinion; illnesses are not entities that enter a subject and line up beside each other—everything here forms only a single illness. It is the same alienation, the same mental disturbance, which can present itself in two different but related forms. But let us leave these general questions for the moment to return to our narrative.

After this crisis, Marcelle got up, to my great astonishment, in a perfect state. Her mind was much clearer, her perception sharper, and, as if ironically, she asked me if I wanted her to go have lunch. The German alienist Schüle has already noted such disappearances of the fixed idea after a crisis that seems to be a true discharge or that has modified the balance and distribution of nervous force. For more than twelve days, Marcelle then ate calmly, but the fixed idea reappeared; a crisis that I provoked again was very short, insignificant, and did not have such a good effect. Marcelle got another idea into her head, juxtaposed with the first: that of no longer speaking. And as I no longer received any response and had hardly any influence over her, we had to resort to feeding her through an esophageal tube. The passage of the tube through the nose, which was always difficult, provoked at the fourth session a major hysterical crisis, after which she awoke having, this time, apparently definitively forgotten her two fixed ideas of not speaking and not eating: “It wasn’t my fault,” she told me upon waking, “they were preventing me from speaking and eating.” This improvement lasted only a moment, for a new fixed idea reappeared in the evening, and this idea, the most serious of all, was nothing less than the idea of suicide.

This fixed idea of suicide provoked in Marcelle a kind of episode that lasted more than fifteen days and was terrible. No longer speaking a word to anyone, having constant impulsive movements to kill herself by any means whatsoever, Marcelle had to be watched very closely almost all the time. It was very difficult to know what was happening in her consciousness during that period. I was only able to observe two phenomena of some interest: first, it was only at this time that Marcelle presented a disturbance of auditory perception analogous to her usual disturbance of visual perception. In slightly more lucid intervals, she seemed to make an effort to listen to what I was saying to her, but she would start to laugh, saying: “What are you saying? I don’t understand.” And no matter how much I

repeated, she did not understand any better. In short, she no more understood speech than she previously understood writing. Furthermore, the former verbal kinesthetic hallucinations had clearly transformed into auditory hallucinations. She would listen attentively and point to a spot always outside and to the right, from which the voices came. This detail is interesting for the evolution of verbal kinesthetic hallucinations which, having become auditory in a hysterical patient, may come to completely resemble the hallucinations of the persecuted. This observation also shows us that in this patient, automatic phenomena—hallucinations—have always remained parallel in detail, as in their entirety, to the disturbances of psychological synthesis or perception. If there are only disturbances in the synthesis of kinesthetic images or disturbances of movement, she has only kinesthetic hallucinations; if there are disturbances of auditory perception, here come the auditory hallucinations.

It is clear that with a patient of this kind, no longer understanding anything that was said to her, any moral intervention had to be quite insignificant. This episode ended on its own with a violent nervous crisis. For more than three hours, Marcelle had convulsions, screams, disordered movements that all seemed more or less clearly aimed at injuring or killing herself.

After this last crisis, Marcelle remained for several days in a state of stupor so astonishing that I wondered whether she had ever shown anything like it before. The first phenomenon that struck me when she began to speak again was that she had completely forgotten everything that had just taken place during the preceding weeks and that she had no notion of her last episode. Mr. Arnaud asked me whether I believed this forgetting to be complete and whether, in somnambulism or in other states, the memory of what had just occurred could not be recovered. I cannot say for certain, for Marcelle has never had amnesia phenomena as simple as those ordinarily seen in hysterics. If she is put to sleep now, even deeply, she always seems to have forgotten the previous fifteen days. But I believe she is mistaken, because the memories she has retained are incomplete, have no precise date, no localization, and she connects them to much earlier periods, although in reality they are indeed from this time. Thus, she remembers that one day—she does not know which—she had a dream and absolutely wanted to kill herself by putting her head under her mattress. ‘But,’ she says, “it must have been a long time ago.” In reality, she only ever had that idea during her last episode, and it was one of her typical impulses. But alongside this clear memory is a complete and strange forgetting. She does not know at all what was done when she tried to put her head under the mattress. In reality, she was restrained, closely supervised, and fed with an esophageal tube. Of these events, although quite distinctive, she shows no memory—neither in somnambulism nor through automatic writing. I believe that both this memory and this forgetting can be explained. The last episode, though it lasted fifteen days, is absolutely identical to one of those clouded attacks she has always had. She retains in somnambulism the memory of the automatic phenomena, the dreams that truly existed in her mind, but she retains no memory of the external phenomena, because they were not perceived. She remembers having wanted to kill herself, because she truly thought about it; she does not remember being held by a nurse, because she never

properly understood it. In studying *continuous amnesia* further on, we will have occasion to see that these phenomena of memory and forgetting do not always present themselves in the same way.

In reviewing the phenomena that had occurred over the past few months and the succession of fixed ideas that had followed one another in the patient's mind since my first attempts to destroy them, I thought I noticed a rather curious law: the suggestions had had the effect of disturbing the patient's mind, which, instead of retaining the same fixed idea for years as she used to, had in a few months passed through a series of successively dominant fixed ideas. The illness seemed to shift from a chronic state to an acute state. Moreover, these ideas, which followed one another in this way, seemed to me to reproduce in reverse order all the fixed ideas that this person had had since the beginning of her illness at nineteen years old. The first visual hallucination that I had so easily removed was a very recent memory, a newly formed fixed idea; the ones that followed were the reappearance of older ideas, whose origin went back more than a year. Her fixed idea of not eating dated much further back; it had arisen near the beginning of the illness, and as for the idea of suicide, it simply reproduced the former despair that our patient had experienced around the age of nineteen. Thus, in removing the superficial layer of delirium, I encouraged the appearance of the old, deep-seated fixed ideas that had always remained at the bottom of consciousness. It is this arrangement of fixed ideas that I have since studied under the name of *stratified fixed ideas*. Of Marcelle's fixed ideas accumulated over the course of an illness that had lasted more than five years, the greatest part was thus erased by hypnotic suggestions; the final part—the oldest fixed ideas, against which no action had been possible—disappeared as a result of violent convulsive crises. The mind of our patient was thus freed from these automatic ideas which had obsessed her and rendered her incapable of any regular activity.

Indeed, aside from the forgetting we have noted—and which is nothing extraordinary—Marcelle's condition is in reality excellent, and it seems to me to improve day by day. First of all, there are no more fixed ideas: however she is questioned, in any state, she laughs at all her former ideas; she considers them as ugly nightmares of which she is ashamed, or which she finds ridiculous. "Wasn't I foolish, I was always afraid of those who were supposed to kill me, and I wanted to kill myself—I was completely crazy." Her tone when she speaks of these delusions is that of someone who has come out of a deep sleep and is astonished at having been so disturbed by dreams. Now I observe very large improvements: although I still note a certain hesitation in her movements when she has to raise her right arm, the perception of bodily sensations is almost perfect; there is no longer any disturbance in auditory perception, and there is no longer any serious doubt in the visual perception of external objects. But there is still a weakness, a kind of psychic impotence, in understanding reading: she still cannot clearly 'see in her head.' Her memories are also clearer, and above all, they remain more stable; they are increasing with the things learned each day. Finally, an action she just performed seems to us a good omen. As she was resuming her usual crocheting work, I made fun of her eternal lacework, always the same, and told her to go find a pattern and to start making a new one. I was very surprised to see,

in the following days, that she had obeyed me; not only had she succeeded in copying a new and complicated design, but she had managed to learn it and can now do it from memory. That may seem trivial, but in my opinion, it is significant: depending on whether this faculty of perceiving new things and adapting to them enough to form memories and habits continues to develop or stops, the illness will be cured or will relapse into abulia and fixed ideas.

The future of this patient is indeed quite uncertain. Most of the authors who have described this illness consider it as essentially periodic. Marcelle's improvement, which has already lasted for some time, would be only one of those interruptions of which Legrand du Saulle speaks, and the illness should naturally and spontaneously begin again. We certainly cannot have a firm opinion on this question, which requires long experience, but we believe that the relapses reported by Legrand du Saulle might perhaps be explained differently. Marcelle seems cured, but I know that she still possesses an extraordinarily weak mind. She remains hypnotizable and highly suggestible, just as she was on the first day I studied her; this is a necessary consequence of her weakness of thought. I can, with a word, provoke all sorts of modifications in her movements or thoughts. She also retains subconscious acts and even automatic writing, which has not disappeared. (It is true that this automatic writing declares that Marcelle is perfectly and forever cured; I would like to have the same confidence.) Some people, it is true, consider these phenomena—suggestibility and mediumistic writing—as completely natural things, perhaps even as qualities of a sound mind. We cannot share that opinion, and we consider these two traits as signs of a persistent and very dangerous weakness. No doubt I take all possible precautions to restrain this suggestibility and to prevent Marcelle from being subject to suggestions from the first person she encounters, but I believe these precautions are rather illusory. When this person returns home, which will happen soon, she will need to make very great mental efforts to adapt to a situation she has not occupied for years. It is certain that she will experience great fatigue and that her power of perception will again diminish. She will then be at the mercy of every emotion, every word, every striking spectacle that she might perceive. And I would not be surprised if this person were to return once more with a fixed idea, with some persistent emotion that would bring back the same kinds of episodes. The illness is perhaps not periodic in itself and by necessity, but it leaves patients for a long time in a mental state that predisposes them to relapse. An idea of this kind has already been expressed by M. Magnan concerning periodic madness; it seems to us especially true for delusions of doubt and fixed ideas. Marcelle is thus not fatally condemned to fall back into her delirium, but she will need, for a long time, specific exercises, a genuine moral hygiene, and a host of precautions to protect a mind whose principal characteristic is fragility.

Conclusion

The science we are dealing with is still very incomplete, and the text must be deepened by means of mathematics or by apparatuses of often extraordinary

precision. Psychology does not, in our view, lend itself well to such measurements: the general nature of the phenomena, their thousand variations, their changing conditions are not well enough known for one to boast of measuring one of them in isolation from the others. It is useless, and even dangerous, to take a microscope to do gross anatomy—one risks distorting what one is observing. For us, experimental psychology is still much simpler: it consists above all in knowing one's subject well—in their life, their temperament, their character, their ideas, etc.—and in being convinced that one never knows them well enough. One must then place this person in simple and determined circumstances and note exactly what they do and say. Examining actions and speech—this is still the best way to understand a person, and we do not find it either useless or tedious to write down word for word the ravings of a madwoman. This method has allowed us to review or discover, in the patient we have studied, many things that are not without interest for pathological psychology. We shall summarize them as follows:

(1) The symptoms presented by our patient can be classified into two categories: episodic and variable phenomena, which treatment can easily modify, and deeper, constant phenomena, which are modified only with great difficulty.

(2) The phenomena that seem to us accessory are the fixed ideas and the impulses. Entirely analogous to hypnotic suggestions, these fixed ideas originate in an emotion, in some incident that struck the patient's mind at a given moment; they can develop to the point of completely invading consciousness and temporarily appearing to be the primary illness; they can vary, disappear under different influences: emotions, crises, or hypnotic treatment.

(3) Beneath these ideas lies a permanent psychological state that precisely explains this suggestibility. This state manifests through abulia, continuous amnesia, and various disturbances of perception; it constitutes the foundation of the illness. It is this state that appeared first, that made the fixed ideas possible, that persists beneath them, and that unfortunately seems to remain to a great extent even after their disappearance.

(4) If one seeks to determine more precisely the nature of this 'morbid foundation,' one sees that it closely resembles the mental weakness which we previously described in hysterics under the name of 'psychological disaggregation with narrowing of the field of consciousness,' but it differs from it in several characteristics which it has not been possible to study in detail here. We have only shown that it essentially consists in a weakening of the faculty of synthesis which, at every moment of life, must newly coordinate our sensations and our images. It is unnecessary to insist on this proposition—it is too evident—that this psychological state depends on a particular cerebral condition determined by heredity and probably also by typhoid fever. One may designate this state by the words exhaustion, torpor, or sleep: as long as histology or chemistry have not taught us more about the nature of this cerebral modification, these words remain, in our view, quite vague and are hardly more than translations of the observed psychological phenomena.

(5) The study of this weakening has allowed us to review many things that are of interest to the psychologist: the importance of the novelty of actions for the will, the role of this will in perceptions that appear most simple, the necessity of voluntary synthesis to establish habits and memories, the relationship between doubt and the failure of perception, the development of various hallucinations. We therefore believe that this study, though narrow and limited to a single person, is not without value for psychology. We thank Dr. Falret, who authorized us to carry it out and who, with such kindness, allowed us to benefit from his teaching on mental illnesses.

Pierre Janet